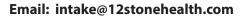
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





RITUXIMAB ORDER FORM					
Date:		ICD	ICD-10 Code:		
Patient Name:		Alle	Allergies:		
Date of Birth:		Wei	ight:lbs OR	kg	
Therapy Status			Provider Information		
		Ord	Ordering Provider:		
□ New Start		Prov	Provider NPI:		
I <sup>—</sup>			Provider Phone:		
☐ Continuing Therapy:			Provider Fax:		
Last Dose:			Provider Address:		
		FIO			
MEDICATION ORDER					
Rituximab	☐ Administer 1,000mg IV on day 1and day 15 per protocol. Repeat course every weeks ☐ Administer mg IV to be given per		Refills for one year from date of	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior	
Please Specify:	protocol every weeks.		signature unless indicated below.	to first infusion:	
Rituxan, Ruxience or	✓ Pre-medications will be given as indicated belo		Refills	✓ Hepatitis B Surface Antigen.	
Truxima if desired**	unless otherwise specified. Antihistamine dosage and route to be determined by on site provider.			√ Hepatitis B Core Antibody, Total (Not IgM)	
PRE-MEDICATIONS  **To be given 30-60 minutes prior to infusion**					
Oral IV					
✓ Acetaminophen:325mg 500mgX650mg			Dexamethasone: 4mg 8mg		
☐ Loratadine:10mg			✓ Diphenhydramine:25mg50mg		
☐ Cetirizine:10mg  ✓ Diphenhydramine: 25mg50mg			Famotidine:20mg40mg		
☐ Famotidine: 20mg40mg			✓ Methylprednisolone: 125mg		
☐ Ibuprofen: 200mg400mg600mg			☐ Hydrocortisone:100mg		
☐ Ondansetron: 4mg 8mg			☐ Ondansetron:4mg8mg ☐ Other:		
□ Other:					
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTHER REQUIRED DOCUMENTATION		
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**		• F	(Please fax this signed order form, along with the following documents to 800-223-4063)  • History & Physical, Last Office Visit Note  • Patient Demographics and Insurance Information  • Medication List  • Recent Lab Work		
By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)					
By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.					
Dispense as Written:		_	Substitution Allowed:		
Prescriber Name	 Date	   Pr	escriber Name	 Date	