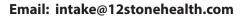
TwelveStone Health Partners

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 [—] | | | 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 | |