



MEDICATION ORDERS

RITUXIMAB (RITUXAN)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: <input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Rheumatoid Arthritis ICD 10 Code: M06.9
<input type="checkbox"/> Chronic Lymphocytic Leukemia ICD 10 Code: C91.10
<input type="checkbox"/> Other: _____ ICD10 Code: _____

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	

MEDICATION ORDERS
<input type="checkbox"/> Rituxan 1000mg IV every 14 days for two doses ONLY
<input type="checkbox"/> Rituxan 1000mg IV every 14 days for two doses; repeat every 6 months
<input type="checkbox"/> Rituxan 1000mg IV once <input type="checkbox"/> Rituxan 375mg/m ² IV every _____
Refills: <input type="checkbox"/> None <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> OTHER: _____
** Order will expire one year from date signed.
<ul style="list-style-type: none">• New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.• Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PREMEDICATIONS
<input checked="" type="checkbox"/> acetaminophen (Tylenol) 1000mg PO, 30 minutes prior to Rituxan infusion
<input checked="" type="checkbox"/> diphenhydramine (Benadryl) 50mg IVPB, 30 minutes prior to Rituxan infusion (decrease Benadryl to 25mg IVP for patients over 65 years old)
<input checked="" type="checkbox"/> famotidine (Pepcid) 20mg IVP, 30 minutes prior to Rituxan infusion
<input checked="" type="checkbox"/> methylprednisolone (Solu-Medrol) 125mg IVPB 30 minutes prior to Rituxan infusion
<input type="checkbox"/> Other: _____

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION
Office Contact Name:
Prescribing Providers Name: Provider NPI:
Office Address: City: State: Zip:
Office Phone Number: Office Fax Number:
Physician Signature: Date:

Contact us with questions at: **Montgomery (334) 273-7000 or Prattville (334) 351-1000**

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207