

Rituxan Order Form (rituximab)

FAX TO: 817-472-7213

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

M06.9 Rheumatoid Arthritis

M31.30 Granulomatosis w/Polyangitis (Wegener's Granulomatosis GPA)

M31.7 Microscopic Polyangitis

Other: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

LAB RESULTS: Include Negative Hepatitis B within 3 years.

PRESCRIPTION

Pre-Medications

Acetaminophen: 650 mg PO

Diphenhydramine: 25 mg IVP

Methylprednisolone: 125 mg SIVP

Other: _____

RITUXAN (rituximab)

Infuse in 250-550 mL of 0.9% Sodium Chloride

Loading Dose (SELECT ONE)

IV: Infuse 1000 mg

IV: infuse 375 mg/m² – **Required** → Height: _____ Weight: _____ lbs or _____ kg

Frequency and Duration (SELECT ONE)

Infuse single dose

Infuse every week for 4 weeks total

Infuse initial dose at day 1 followed by 2nd dose on day 15, then repeat cycle every _____ months for one year

Other frequency: _____ for one year

Is the patient on any other disease modifying therapy? Yes No

If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 60 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____