

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.

Dose: (SELECT ONE)

- IV: infuse 1000 mg
- IV: infuse 375 mg/m² – **Required** → Height: _____, Weight: _____ lbs or _____ kg

Frequency & 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 dose every _____ months for one year
- Other frequency: _____ for one year

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

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

Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ **Signature:** _____
Date: _____ NPI #: _____ Specialty: _____
Supervising Physician: _____ (If Applicable)
Address: _____ City: _____ State: _____ Zip: _____
Contact Name: _____ Phone: _____ Fax: _____ Email: _____