Ruxience Order Form
(rituximab-pvvr)

FAX TO: 972.499.9210

PATIENT INFORMATION

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

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

☐ 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: _____

Ruxience (rituximab-pvvr)

Infuse in 250-550 mL of 0.9% Sodium Chloride.

Dose: **(SELECT ONE)**
☐ **IV:** Infuse _____ mg
☐ **IV:** infuse 375 mg/m2 – Required Height: _____, Weight: _____ lbs or _____ kg

Frequency: **(SELECT ONE)**
☐ Once weekly for one year
☐ Other: _____ 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: _____