medix infusion

Truxima Order Form
(rituximab-abbs)

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

☐ 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: ___________________________

Truxima (rituximab-abbs)

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: ______________________________