medix infusion

Rituxan Order Form
(rituximab)

FAX TO: 972.499.9210

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/m^2 – **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 cycle 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: _____