

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: _____

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 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: _____