Rituximab Form
(rituximab)

medix Infusion

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 Granformatosis 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: _____

RITUXIMAB (rituximab)

  Rituxan (rituximab) or Biosimilar as dictated by patient's insurance*
  Medix Infusion will determine apporpriate product pbased upon benefit investigation
                                OR
  Rituximab product _____ (**DO NOT SUBSTITUTE**)
  Infuse in 250-550 ml of 0.9% Sodium Chloride

MEDIX USE ONLY
MEDIX USE ONLY   Product to be Used: Rituxan   Truxima   Ruxience

Loading Dose (SELECT ONE)

  IV: Infuse 1000 mg   **IV:** infuse 375 mg/m^2 – **Required** → Height: _____ Weight: _____ lbs **or** _____ kg

Frequency and 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

Is the patient on any other disease modifying therapy?   Yes   No
If yes, please note therapy and last dose: _____

Post Treatment Observation: The patient is observed for 60 minutes following the first administration.

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

Comments:

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____