

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: _____

RUXIENCE (rituximab-pvvr)

Infuse in 250-550 mL of 0.9% Sodium Chloride

Loading 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

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

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

Adverse Events: 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: _____