

**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  
Methylprednisolone: 125 mg SIVP  
Diphenhydramine: 25 mg IVP  
Other: \_\_\_\_\_

**TRUXIMA (rituximab-abbs)**

Infuse in 250-550 mL of 0.9% Sodium Chloride

**Loading Dose (SELECT ONE)**

IV: Infuse 1000 mg  
IV: infuse 375 mg/m<sup>2</sup> – **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 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: \_\_\_\_\_