Rituximab Order Form
(rituximab)

medix infusion

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)

☐ M06.9 Rheumatoid Arthritis
☐ M31.30 Granulomatosis w/Polyangitis (Wegener's Granuformatosis - GPA)
☐ M31.7 Microscopic Polyangitis
☐ Other: _____

Patient status:

☐ New to therapy
☐ Continuing therapy
☐ (date of last dose _____)

Weight: _____ ☐ lb ☐ kg **Height:** _____

Allergies: _____

PRESCRIPTION

Pre-Medication (Required)

- Acetaminophen: 650 mg PO
- Diphenhydramine: 25 mg IVP atient's demographic and insurance information
- Methylprednisolone: 100 mg SIVP

☐ Other: _____

RITUXIMAB (rituximab)

☐ Rituxan (rituximab) or Biosimilar as dictated by patient's insurance*
Medix Infusion will determine appropriate product based upon benefit investigation
☐ Rituximab product _____ (DO NOT SUBSTITUTE)

Dose:

☐ 1000 mg IV
☐ 500 mg IV
☐ 375 mg/m^2 IV

Frequency and Duration:

☐ Single dose
☐ Once weekly for four weeks
☐ Initial dose at day 1 followed by second dose on day 15, then repeat cycle every _____ for one year
☐ **Other Frequency:** _____ for one year

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

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

Other Orders:

_____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting labs/diagnostics:

- Negative Hepatitis B within 3 years. Includes Heptatitis B surface antigen and Hepatitis B core antibody total (not IgM)
- CBC differential and platelet counts every 2-4 months for a patients with RA, GPA, or MPA
- Recommended: Quantitative immunoglobulins

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____