medix infusion

Rituximab® Order Form
(rituximab)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Ht: _____ Wt: _____☐ lbs ☐ kg Primary Language: _____

Allergies: _____Patient Preferred Location: _____

Diagnosis

ICD 10 Code

☐ M05.A Abnormal Rheumatoid Factor and Anti-Citrullinated Protein Antibody with Rheumatoid Arthritis
☐ M06.9 Rheumatoid Arthritis
☐ M31.30 Granulomatosis w/Polyangitis (Wegener's Granulomatosis GPA)
☐ M31.7 Microscopic Polyangitis
Other: _____

Medication Order

Pre-Medications - Administer 30 minutes prior to Rituximab Administration

☐ Acetaminophen: 650 mg PO ☐ Diphenhydramine: 25 mg IVP
☐ Methylprednisolone: 125 mg SIVP Other: _____

RITUXIMAB (rituximab)

☐ Rituxan or Biosimilar as dictated by patient's insurance*
**Medix Infusion will determine appropriate product based upon benefit investigation*

Select Dose

☐ **IV:** Infuse 1000 mg
☐ **IV:** Infuse 375 mg/m^2
☐ **IV:** Infuse _____mg

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

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

Required Clinical Documentation

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.**

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

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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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