Palmetto INFUSION

Phone: 1-800-809-1265 Fax: 1-866-872-8920

MRN:_____

DOB:_____

STANDARD Rituxan® (rituximab) PLAN OF TREATMENT for GPA or MPA

NOTE: Patient ***may be ineligible*** to receive rituximab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, newly diagnosed cardiac arrhythmias, severe abdominal pain or vomiting, and/or surgery.

1. Patient Name:_____ Height (inches):_____ Weight (lbs): _____

2. Allergies: _____

3. Diagnosis:

☐ **M31.30 Granulomatosis with Polyangiitis (GPA/Wegener's Granulomatosis)** ☐ **M31.7 Microscopic Polyangiitis (MPA)**

☐ Other ICD-10 Code:_____ Diagnosis description: _____

4. Pre-medications: *Administered 30 minutes prior to infusion* ***as selected:***

**** Premedication of Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion***

Acetaminophen:	**Diphenhydramine:** □ 25 mg IVP, □ 50 mg IVP, □ 25 mg PO, □ 50mg PO or
□ 650 mg PO	Alternate oral antihistamine to diphenhydramine:
□ 500 mg PO	□ Cetirizine 10 mg □ Loratadine 10 mg Fexofenadine □ 60mgs or □ 180mgs
□ 325 mg PO	**Methylprednisolone:** □ 125 mg IVP □ 40 mg IVP or other_____mg IVP
□ 1000 mg PO	Famotidine: □ 20mg PO, □ 40mg PO, □ 20mg IVP, □ 40mg IVP

Pre-medicate with other: _____

5. DOSE:

☐ Rituxan® (rituximab) **375mg/m² per** 250-500ml Sodium Chloride 0.9% IV to infuse per protocol ***OR***

☐ Other Dose: _____

6. FREQUENCY:

☐ Orders to be completed once weekly x 4 weeks

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

7. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

8. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised 6/21/18

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MRN:_____

DOB:_____

Guidelines for Prescribing Rituxan® (rituximab) for GPA or MPA

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**
* Rituximab, in combination with glucocorticoids, is indicated for the treatment of adult patients with Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA).

___ If patient is switching biological therapies, then MD must specify wash-out period prior to starting Rituxan® as specified of_____weeks. Last known biological therapy:_____and last date received:_____. (Include copy of last Rituxan® infusion record if available and currently on therapy)

___ Other as requested: _____

_____

Pre-Screening:

___ **Required Hepatitis screening to include: Hepatitis B Surface Antigen (HBsAg) and Total Hepatitis B Core Antibody (anti- HBc)**
***Rituxan® is contraindicated in patient with active HBV. Patients who are negative for surface antigen HBsAg (-) and positive for HB core antibody HBcAB (+) or positive for surface antigen HBsAg (+), should consult liver disease experts before starting and during treatment.**

***Other:** Glucocorticoids administered as methylprednisolone 1000 mg intravenously daily for 1 to 3 days followed by oral prednisone 1 mg/kg/day (not to exceed 80 mg/day and tapered per clinical need) are recommended to treat severe vasculitis symptoms. This regimen should begin within 14 days prior to or with the initiation of rituximab and may continue during and after the 4-week course of rituximab treatment. Methylprednisolone Plan of Treatment are available *at www.palmettoinfusion.com* if needed.

** Warnings/Precautions: • **Hepatitis B Virus Reactivation**- Screen all patients for HBV infection by measuring HBsAg and anti-HBc (antibodies) before initiating treatment with Rituxan®. For patients who show evidence of prior hepatitis B infection (HBsAg positive or HBsAg negative but anti-HBc positive), consult with physicians with expertise in managing hepatitis B regarding monitoring and consideration for HBV antiviral therapy before and/or during Rituxan® treatment. HBV reactivation has been reported up to 24 months following completion of Rituxan® •Glucocorticoids administered methylprednisolone IV premed or its equivalent 30 minutes prior to each infusion are recommended to reduce the incidence and severity of infusion reactions. Evaluation of immunizations should be completed prior to and live vaccines should not be given before or concurrently. **Serious Infections:** including fatal, bacterial, fungal, and new or reactivated viral infections can occur during and following the completion of Rituxan®. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Revised 6/21/18