Palmetto INFUSION®

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

Referral Status:			MRN:
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Rituximab Unspecified Plan of Treatment for GPA/MPA

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐ See list ☐ NKDA	

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ M31.30 - Granulomatosis with Polyangiitis (GPA/Wegener's Granulomatosis)
- ☐ M31.7 - Microscopic Polyangiitis (MPA)
- ☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Most recent labs including CBC with diff		NEXT INFUSION DATE:
4	Full medication list / Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** Hepatitis B Panel for new start patients		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*Per FDA labeling, Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion

IV	Diphenhydramine	☐	25mg	☐	50mg				
	Methylprednisolone	☐	40mg	☐	125mg	☐	Other:		
	Famotidine	☐	20mg	☐	40mg				
	Other:	☐							
PO	Acetaminophen	☐	325mg	☐	500mg	☐	650mg	☐	1000mg
	Famotidine	☐	20mg	☐	40mg				
	Diphenhydramine	☐	25mg	☐	50mg				
	Fexofenadine	☐	60mg	☐	180mg				
	Cetirizine	☐	10mg						
	Loratadine	☐	10mg						
	Other:	☐							

DRUG PRODUCT:

- ☐ Rituxan
- ☐ Ruxience
- ☐ Truxima
- ☐ Riabni

☐ **Biosimilar may be used according to payer guidelines**

If selected, prescriber must sign substitution permitted line

INDUCTION DOSE:

- ☐ 375mg/m2 per 250 - 500ml NS IV to infuse per step protocol once weekly x 4 weeks
- ☐ Other:_____

SPECIAL/LAB ORDERS:

- ☐ _____
  _____

MAINTENANCE DOSE: (begin ____ months after last induction dose)

- ☐ 500mg/500ml NS IV to infuse per step protocol
- ☐ 1000mg/500ml NS IV to infuse per step protocol
- ☐ Other:_____
  _____

MAINTENANCE FREQUENCY:

- ☐ Infuse dose every ☐ 4 months ☐ 6 months
- ☐ Other:_____

☑ Refills x 12 months unless noted otherwise here:

Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.

LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	