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**: **HBsAg, anti-HBc 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:	☐					

SPECIFIC MEDICATION:

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

☐ **Any rituximab biosimilar may be used according to payer guidelines**

INDUCTION DOSE:

- ☐ 375mg/m^2 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
- ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post observation if indicated.

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	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- [ ] **Patient demographics - address, phone number, SS#, etc.**
- [ ] **Insurance information - copy of the card(s) if possible**
- [ ] **Plan of Treatment/Orders**
- [ ] **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- [ ] **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com