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

Rev 4.29.25

PATIENT DEMOGRAPHICS:

Patient Name:					
Patient's Phone:		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:

1. Insurance information
2. Most recent History & Physical
3. Most recent labs including CBC with diff
4. Full medication list / Tried and failed therapies
5. **REQUIRED: HBsAg, anti-HBc for new start patients**

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **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:_____

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:_____

SPECIAL/LAB ORDERS:

- ☐ _____

☑ 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.

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	