

**RITUXAN® Infusion Form
For GPA or MPA**

**Fax Referral To:
877-438-9380**



Birmingham, AL
F: 205-271-9971

Huntsville, AL
F: 256-417-6408

Knoxville, TN
F: 865-934-0249

Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
Phone Number: _____ Email Address: _____
Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Granulomatosis with Polyangiitis (GPA)
_____ Microscopic Polyangiitis (MPA)
_____ Other: _____

Please attach the following: 1. List of current Medications, Previous Drug Therapy History, including therapies trailed/failed and date of last administration: therapy: _____ Date: _____ Desired Washout Period: _____ weeks 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs including TB Screening Results and Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody) 5. Infusion Center - Lab Orders (Check for Infusion Center to Manage): Obtain CBC with diff and platelets every _____ Corticosteroid Regimen: Has your patient started on a steroid regimen prior to receiving Rituxan? Yes No If yes, provide corticosteroid regimen: _____

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: RITUXAN® (rituximab)

Administer Rituxan IV as per the below parameters:

Start Dose: 375 mg/m2 once weekly x 4 weeks

Other: _____

Maintenance Dose: _____

Pre-Medication Orders:

Administer **Acetaminophen** 650 mg PO; **Diphenhydramine** 50 mg PO orally 30 minutes prior to infusion and adjust to patient's needs PLUS

Induction Steroid Therapy: **Methylprednisolone** 1000mg IV Daily x 3 doses prior to Rituxan therapy or adjusted according to prior steroid dosing regimen.

If induction steroid therapy is completed, **Methylprednisolone** 100 mg IV 30 mins prior to infusion.

Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's NPI#

Physician's Address

Prescriber's Signature

Date