



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

RITUXIMAB ORDER GPA/MPA

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies NKDA Allergies: _____

Height: _____ Weight: _____

Indication:

M31.30 ___ Granulomatosis w/ Polyangiitis (GPA/ Wegener's)

M31.7 ___ Microscopic Polyangiitis (MPA)

Other _____

DRUG: Rituxan | Truxima | Riabni | Ruxience

Rituximab-per insurance preferred

Rituxan

Truxima (rituximab-abbs)

Riabni (rituximab-arrx)

Ruxience (rituximab-pvvr)

<p>INDUCTION DOSES:</p> <p><input type="checkbox"/> 375mg/m² IV every week X 4 weeks</p> <p><input type="checkbox"/> Methylprednisolone 1000mg IV for: Day 1 Day 2 Day 3</p> <p><input type="checkbox"/> Other _____</p>	<p>MAINTENANCE DOSES:</p> <p><input type="checkbox"/> 500mg IV at day 0 and 15 (approximately)</p> <p><input type="checkbox"/> 500mg IV every 6 months</p> <p><input type="checkbox"/> 100mg IV methylprednisolone 30 minutes prior to each infusion</p> <p><input type="checkbox"/> Other _____</p>
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PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion-REQUIRED

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion-REQUIRED

Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____

DISCLAIMER: Referring provider attests patient has been instructed to take oral prednisone