RITUXAN® Infusion Form For GPA or MPA

Fax Referral To: 877-438-9380

CONTINUUM Health

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. Presriber's Signature (SIGN BELOW)

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

_____ _____

Physician's NPI# Physician's Address

_____ _____

Prescriber's Signature Date