INTRAMED Plus
infusion services

RITUXAN®
For GPA or MPA

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis: _____ Granulomatosis with Polyangiitis (GPA) ICD-10 Code: M31.30_____

_____ Microscopic Polyangiitis (MPA) ICD-10 Code: M31.7_____

_____ Other: ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

Patient
Weight: _____ lbs.
Height: _____ in.

- Clinical MD Notes, labs, test supporting primary diagnosis
- Pre-Screening results for Hepatitis B Panel
- Previous Drug Therapy History, including therapies trialed and or failed and date of last infusion:
  - ❑ Previous biologic therapies: _____ Date: _____
  - ❑ Washout period of _____ weeks desired prior to the initiation of this ordered therapy
- Infusion Center – Lab Orders (Check for Infusion Center to Manage):
  - ❑ Obtain CBC with diff and platelets every _____
- Current Medication List: _____

Corticosteroid Regimen: Has patient started on a steroid regimen prior to receiving Rituxan? ❑ Yes ❑ No

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RITUXAN® (rituximab) J Code: J9312

4. Drug Order: Administer Rituxan IV as per the below parameters:

❑ **Induction Dose:** ❑ 375 mg/m2 once weekly x 4 weeks or ❑ Other: _____

❑ **Maintenance Dose:** ❑ 1,000 mg on Day 0 & 14 every _____ or ❑ Other: _____

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 1000 mg IV Daily x 3 doses prior to Rituxan therapy OR

❑ If oral (i.e. PO) induction therapy is completed, Methylprednisolone 100 mg IV 30 minutes prior to each infusion

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

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

5. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**