

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 ICD10 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:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Pre-Screening Documentation
 Hepatitis B Screening Results (including Hep B surface antigen & Total Hep B Core Antibody)
- 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 _____
- Corticosteroid Regimen: Has your patient started on a steroid regimen prior to receiving Rituxan? Yes No
 If yes, provide corticosteroid regimen: _____

Patient Weight: _____ lbs.
Patient Height: _____ in.

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: _____
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 this form and utilizing these 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: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337
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