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 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.
**Height:** _____ in.

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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:** _____

**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 | INFUSION CENTER LOCATIONS |
|---|---|
| CENTRAL FAX **803.999.1754** | **COLUMBIA CHARLESTON GREENVILLE** |
| **ALTERNATE FAX 803.999.1887** | **CENTRAL INTAKE PHONE 803.999.1960** |