

March 2024

# LOWCOUNTRY Rheumatology

A Member of Articularis Healthcare Group, Inc.

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><b>INDUCTION DOSES:</b></p> <p><input type="checkbox"/> 375mg/m<sup>2</sup> every week X 4 weeks</p> <p><input type="checkbox"/> 1000mg IV at day 0 and 15 (approximately)</p> <p><input type="checkbox"/> Other _____</p>	<p><b>MAINTENANCE DOSES:</b></p> <p><input type="checkbox"/> 500mg IV at day 0 and 15 (approximately)</p> <p><input type="checkbox"/> 500mg IV every _____</p> <p><input type="checkbox"/> Other _____</p>
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**PREMEDICATION ORDERS:** *antihistamine, acetaminophen and 100mg methylprednisolone are recommended in the PI*

Acetaminophen po:  1000mg  500mg 30 min prior to infusion.

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

Solu-Medrol:  62.5mg IVP  100mg IVP  Other \_\_\_\_\_ 30 min prior to infusion.

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: \_\_\_\_\_