Phone: 616-954-0600 Fax: 616-954-1675

Rituximab IV GPA/MPA

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: ___________________________ **Patient Weight:** ________lbs / kg **Height:**_________

ICD-10 : ________________________, ____________________________, ____________________________

Has the patient tried corticosteroids? ☐Yes ☐ No
Has the patient tried cyclophosphamide? ☐Yes ☐ No

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

Hepatitis B Virus Screening is required before first dose: ☐ **COPY ATTACHED**
Result Date: ________/_______/_________ Result ***(circle one):*** **Positive** **Negative**

Labs to be collected: ☐CMP ☐CBC w/o diff ☐CBC w/diff ☐CBC w/man diff ☐ Other:__________
Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:________________

Pre-Medications:				
	Diphenhydramine PO or IV	25mg or 50mg	☐Yes	☐ No
	Acetaminophen PO	650mg	☐Yes	☐ No
	Methylprednisolone IVPush	125mg	☐Yes	☐ No

☐ **Pharmacist to select product**

☐ **Rituxan (rituximab) IV**
☐ **Ruxience (rituximab-pvvr) IV**
☐ **Truxima (rituximab-abbs) IV**

Dose: 375 mg/m² BSA=_________________ mg

Frequency: Weekly x 4 weeks

RX Expiration Date: _____/_____/_____

Printed Provider's Name: ____

Provider Signature: ____

Office Phone Number: ______________________**Office Fax Number:** ____________________________