Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

Rituxan for GPA/MPA Order
(Rituximab)

Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, Current Medications, Letter of Medical Necessity and BIF

Date: _____/_____/_____

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

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Calculated BSA:_____

DX CODES: ***ICD-10*** **:** _____, _____, _____

History of CHF / COPD □No □ Yes if yes explain:_____

Antihypertensive medications held for 12 hrs. prior to Rituxan infusion: □Yes □ No
List medications to be held:_____

LABS to be drawn: □ **CBC** □ Other: _____

Pre- Medications:	**Diphenhydramine PO/IV**	25mg or 50 mg	□Yes □ No
	Acetaminophen PO	650mg	□Yes □ No
	Solu-Medrol IV	_____mg	□Yes □ No

Rituxan IV Dosage:

375mg/m^2 (BSA)=_____mg IV once weekly x 4 weeks

Start Date of Infusion: _____/_____/_____ **Rituxan Infusion #** _____

Infuse per the Infusion Associates Rituxan infusion protocol.

Has patient received Rituxan in the past? □No □Yes, please explain and list dates/doses

_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____