



St. Charles Health System

Adult Ambulatory Infusion Order
Rituximab (RITUXAN)
Or biosimilar

Patient Name:

Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____

Weight: _____ kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE _____**
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment, and the patient should not be infected. Please send results with order.
3. If patient is at high risk for TB exposure, a Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. Patient should have regular monitoring for hepatitis B, infection, and renal dysfunction.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- Hepatitis B surface antigen and core antibody total test results scanned with orders.
- Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders if patient is at high risk for TB exposure.
- Chest X-Ray result scanned with orders if TB test result is indeterminate.
- TB screening is not necessary. Patient is not at high risk for TB exposure

LABS:

- CBC with differential, Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**
- CMP, Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**
- IgG, SERUM, Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**

NURSING ORDERS:

1. TREATMENT PARAMETER #1– Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. TREATMENT PARAMETER #2 – Verify than ANC is above 1000 (1×10^3) prior to infusion.



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3. First infusion/if it has been greater than/equal to 6 months since last infusion/history of reaction: Start infusion at 50 mg/hour for the first hour. If no infusion related reactions are seen, then increase by 50 mg/hr every 30 minutes to a maximum rate of 400 mg/hour.
4. Subsequent infusions: Infuse riTUXimab via pump at 100 mg/hr for the first hour. If no infusion related reactions are seen, increase rate gradually by 100 mg/hour every 30 minutes to a maximum of 400 mg/hour as tolerated.
5. Rapid riTUXimab infusions can be considered based on institution protocols starting cycle 3 or later who meet eligibility criteria.
 - Rapid infusion dosing; Dose mixed in 500mL NS. Administer 20% of total dose over the first 30 minutes (200 mL/hr) then the remainder of the dose over the next 60 minutes (400 mL/hr). Total infusion time is 90 min.
6. NURSING COMMUNICATION – HYPERSENSITIVITY/INFUSION REACTION #1 -- Monitor patient for riTUXimab infusion related reactions for 1 hour (first infusion) or 30 minutes (second infusion) after completion of riTUXimab infusion. Monitoring not required for third infusion and beyond, if no previous infusion reactions. Lengthened monitoring recommended for previous infusion reactions, contact provider for guidance.
7. VITAL SIGNS -- First infusion: During riTUXimab infusion obtain vital signs at baseline, then every 15 minutes for the first hour, then every 30 minutes with rate escalation, then every hour for the duration of the infusion.
8. VITAL SIGNS -- Subsequent infusions: During riTUXimab infusion obtain vital signs at baseline, then every 30 minutes with rate escalation, then every hour for the duration of the infusion.
9. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

- acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- diphenhydrAMINE (BENADRYL) injection 25 mg, intravenous, ONCE, every visit.
- methylPREDNISolone sodium succinate (SOLU-MEDROL), 100 mg, intravenous, ONCE, every visit
- Other: _____

MEDICATIONS:

Biosimilar selection (must check one) – applies to all orders below

- RITUXAN (riTUXimab) (St. Charles preferred brand)
- TRUXIMA (riTUXimab-abbs)
- RUXIENCE (riTUXimab-pvvr)
- RIABNI (riTUXimab-arrx)
- _____



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At St. Charles clinics, if insurance requires a different biosimilar agent, pharmacy will update the order per CDTM.

Only check this box if it is NOT okay to substitute for insurance. Dispense as written (DAW).

RiTUXimab will be rounded to the nearest 100 mg increment unless the provider specifies otherwise.

No dose rounding (Reason for medical necessity): _____

Select riTUXimab dose

- riTUXimab 1000 mg in sodium chloride 0.9%, infuse per nursing order
- riTUXimab 375 mg/m² in sodium chloride 0.9%, infuse per nursing order
- Other (please specify): _____

Interval

<input type="checkbox"/>	Once
<input type="checkbox"/>	Administer riTUXimab every 2 weeks for 2 doses, subsequent 2 dose course give two weeks apart every 24 weeks
<input type="checkbox"/>	Administer riTUXimab every 2 weeks for 2 doses, subsequent 2 dose course give two weeks apart every 16 weeks
<input type="checkbox"/>	Administer riTUXimab once weekly for 4 doses
<input type="checkbox"/>	Administer riTUXimab once every 6 months
<input type="checkbox"/>	Other (please specify):

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebuler, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:



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Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed