

RITUXAN (rituximab) ORDER FORM

PATIENT NAME: _____ DOB: _____ WT: _____ HT: _____

ALLERGIES: _____

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: RITUXAN (rituximab) ☐ NO ☐ YES

BRAND: _____ LAST DOSE DATE: _____

DIAGNOSIS: _____ ICD 10 CODE(S): _____

Infusion Solutions will select therapeutically interchangeable rituximab product based on payor requirements, product availability, and indication:

1) Rituxan (rituximab); 2) Truxima (rituximab-abbs); 3) Ruxience (rituximab-pvvr); 4) Riabni (rituximab-arrr)

☐ Substitution Permitted ☐ Dispense as written (indicate brand): _____

MEDICATION ORDERS

DOSE:

- ☐ 500 mg IV
☐ 1000 mg IV
☐ 375 mg/m² IV
☐ Other: _____

FREQUENCY:

- ☐ Day 0 and 14, x 1 course
☐ Day 0 and 14, repeat 2 dose treatment cycle in 6 months
☐ Day 0, 7, 14, and 21, x 1 course
☐ Other: _____

PREMEDICATION: 30 minutes prior to infusion

- | | | |
|---|---|--|
| <input type="checkbox"/> Methylprednisolone 100 mg IV | <input type="checkbox"/> Diphenhydramine 25 mg IV | <input type="checkbox"/> Diphenhydramine 25 mg PO |
| <input type="checkbox"/> Acetaminophen 500 mg PO | <input type="checkbox"/> Diphenhydramine 50 mg IV | <input type="checkbox"/> Diphenhydramine 50 mg PO |
| <input type="checkbox"/> Acetaminophen 1000 mg PO | <input type="checkbox"/> Cetirizine 10 mg PO | <input type="checkbox"/> Other (dose/route): _____ |

Orders are valid for 1 year. For a shorter duration, indicate here: _____

STANDARD ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- If no central IV access, RN to insert peripheral IV.
- Obtain weight before each dose
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate AND monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify provider.
- Observe patient for 30 minutes after completion of therapy.

LABS

LAB ORDERS:

- ☐ CBC w/diff ☐ CRP
☐ CMP ☐ Other: _____

LAB FREQUENCY:

- ☐ Every dose
☐ Other: _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- Hepatitis B serology labs or proof of immunity/vaccination
- Baseline labs (CBC w/diff, CMP)

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Tests for cytomegalovirus, herpes simplex virus, parvovirus B19, varicella zoster virus, West Nile virus, hepatitis B and C

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution)

PRESCRIBER SIGNATURE (dispense as written)

PRINT NAME (FIRST AND LAST)

DATE