Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

RiTUXimab Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

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. Medication orders default to rapid rate infusion for subsequent doses. If the standard infusion rates are required contact pharmacy to adjust orders.

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*
- ☐ Liver Set (AST, ALT, BILI TOTAL, BILI DIRECT, ALK PHOS, ALB, PROT TOTAL), 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 – 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. For rapid riTUXimab before releasing order: If previous infusion reaction to riTUXimab noted or last dose ≥ 6 months late from the last treatment due date, contact pharmacist to apply standard riTUXimab order.
3. First Infusion: Infuse RiTUXimab via pump slowly at 50 mg/hr for the first hour. If no infusion related side effect is seen, increase rate gradually (50 mg/hour) every 30 minutes to a maximum of 400 mg/hour. If infusion not tolerated, STOP infusion, follow appropriate hypersensitivity protocol.

For 2 mg/mL standard infusions:
50 mg/hr = 25 mL/hr infusion rate
100 mg/hr = 50 mL/hr infusion rate
150 mg/hr = 75 mL/hr infusion rate
200 mg/hr = 100 mL/hr infusion rate
250 mg/hr = 125 mL/hr infusion rate
300 mg/hr = 150 mL/hr infusion rate
350 mg/hr = 175 mL/hr infusion rate
400 mg/hr = 200 mL/hr infusion rate

4. If no previous infusion related reactions: Infuse rituximab (RAPID) - Total infusion time of 90 minutes (20% of the dose in the first 30 minutes then the remaining 80% over 60 minutes). Total dose delivered in 500 mL normal saline.
   Infusion related reactions during treatment: If infusion not tolerated, STOP infusion, follow appropriate hypersensitivity protocol.
5. 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.
6. 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.
7. 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.
8. 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) capsule, 50 mg, oral, ONCE, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- methylPREDNISolone sodium succinate (SOLU-MEDROL), 125 mg, intravenous, ONCE, every visit

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

- ☐ TRUXIMA (riTUXimab-abbs) ***(OHSU & HMC preferred brand)***
- ☐ RITUXAN (riTUXimab) ***(Adventist preferred brand)***
- ☐ RUXIENCE (riTUXimab-pvvr)
- ☐ RIABNI (riTUXimab-arrx)
- ☐ _____

At OHSU 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).

MEDICATIONS:

PROVIDER TO PHARMACIST COMMUNICATION – If previous infusion to rituximab noted or last dose ≥6 months late from the last treatment due date, pharmacist to apply standard rituximab order and discontinue rapid orders.

riTUXimab 1,000 mg in sodium chloride 0.9%, intravenous, ONCE, Infuse per nursing order.

Interval: ***(must check one)***

- ☐ Weeks 0 and 2 and then 1 dose every 26 weeks thereafter
- ☐ Weeks 0 and 2 every 26 weeks
- ☐ 1 dose every 26 weeks
- ☐ Once
- ☐ Every _____ weeks x _____ doses
- ☐

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT- 133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose, for hypersensitivity or infusion reaction
6. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for infusion related fever
7. meperidine (DEMEROL) injection, 25-50 mg, intravenous, EVERY 2 HOURS AS NEEDED for infusion-related severe rigors in the absence of hypotension, not to exceed 50 mg/hr.
8. sodium chloride 0.9% solution, 1000 mL, intravenous, AS NEEDED, Infuse at 200 mL/hr when infusion is stopped for emergency or PRN medications

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058	Phone (541) 296-7585 Fax (541) 296-7610