ORDERING OFFICE, ALSO FAX:

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

Rituximab (Rituxan)

Provider Order Form

OIS Ohio Infusion Services

Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
☐ NKDA Allergies:		Weight lbs/kg:
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Provider Address:	City:	State: Zip Code:

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other:

PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ Loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other:
Dose: Route: Frequency:

INFUSION THERAPY

☑ Rituximab (Rituxan) in 0.9% sodium chloride or D5W to final concentration of 1-4mg/ml
- Dose: ☐ 1000mg / ☐ _____mg
- Mix in: ☐ 500ml / ☐ 250ml
- Frequency:
  ☐ on Series Day 0 and Series Day 14; repeat series every 24 weeks
  ☐ other_____
- Infusion rate: First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr

  Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg/hr

☑ Flush with 0.9% sodium chloride after completion of infusion
☑ Monitor patient for 30 minutes post infusion
☐ Refills: ☐ Zero / ☐ for 12months / ☐ _____ (if not indicated order will expire one year from date signed)

GENERAL PLAN COMMUNICATION

Ordering Provider: Initial here _____ and proceed to the next page.

ADULT REACTION MANAGEMENT

☐ Observe for **hypersensitivity reaction:** Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation

☐ If reaction occurs:

- Stop infusion
- Maintain/establish vascular access
- Notify referring provider
- Consider giving the following PRN
  1. Acetaminophen (Tylenol) 650mg PO **OR**_____mg for pain or fever > 38 C/100.4 F
  2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
  3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
  4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
  5. Methylprednisolone (Solumedrol) 125mg **OR** _____mg slow IV push.
  6. Other _____
- When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines

☐ **Severe allergic/anaphylactic reaction:**

- If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
  1. Call 911
  2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
  3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
  4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
  5. Have Automated External Defibrillator available
  6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
  7. Discontinue treatment

Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone 100 mg intravenously or its equivalent is recommended 30 minutes prior to each infusion.

Screen all patients for HBV infection by measuring HBsAg and anti-HBc before initiating treatment with RITUXAN. For patients who show evidence of prior hepatitis B infection (HBsAg positive [regardless of antibody status] or HBsAg negative but anti-HBc positive), consult with physicians with expertise in managing hepatitis B regarding monitoring and consideration for HBV antiviral therapy before and/or during RITUXAN treatment.

Patient Name _____ **Patient Date of Birth** _____

Provider Name (Print) _____

Provider Signature _____ **Date** _____

Please fax the order form to (440) 443-0700

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