ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER

ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021

ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

RITUXIMAB OR RITUXIMAB BIOSIMILAR

Patient Name:____ Requested Start Date: ________/______/______
Date of Birth:________/______/_______ Patient Weight: __________________ kg Patient Height: _______________

DIAGNOSIS & ICD-10 CODE:
❑ Rheumatoid Arthritis (ICD-10: ________) ❑ Other: ___________________________ (ICD-10: _________)

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

REQUIRED BASELINE LABS & INFORMATION:

- ✓ CBC & CMP
- ✓ Negative Latent TB Test (Date: ___________ | ❑ QuantiFERON Gold | ❑ PPD | ❑ Chest X-Ray | ❑ Other: ____________________)
- ✓ HBV Screening/Status (Date: ___________ | HepBsAg _________ | HepBsAb _________ | HepB Core Ab _________)

ROUTINE LABS: ❑ CMP | ❑ CBC w/ diff | ❑ LFT | ❑ CRP | ❑ ESR | ❑ Other: ______________
ROUTINE LAB FREQUENCY: ❑ Each Infusion | ❑ Other: _____________

ACCESS: *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYM OIC P&Ps*

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

✓ PRE-MEDICATIONS – Give 30 minutes prior to infusion
- ❑ Acetaminophen 650 mg PO x1 ❑ Diphenhydramine 25 mg PO x1 ❑ Diphenhydramine 50 mg IV x1
- ❑ Loratadine 10 mg PO x1 ❑ Methylprednisolone sodium succinate 125 mg IV x1
- ❑ Other: ____

✓ **RiTUXimab or Biosimilar** per formulary/insurance (RPH USE: riTUXimab | abbs | pvvr | arrx | ______)
- ❑ Fixed dose: 1000 mg IV
- ❑ Weight based: 375 mg/m^2 x _________ BSA (m^2) = _________ mg IV/dose
- ☑ Final Concentration 1-4 mg/mL
- ☑ Initial infusion: Start rate = 50 mg/hr - increase as tolerated every 30 minutes to MAX of 400 mg/hr
- ☑ Maintenance infusion: Start rate = 100 mg/hr - increase as tolerated every 30 minutes to MAX 400 mg/hr

✓ **FREQUENCY:**
- ❑ Induction: Every 2 weeks x 2 doses
- ❑ Maintenance: Every 2 weeks x 2 doses every _________ weeks (no sooner than 16 weeks from last dose)
- ❑ Other: ____

MONITORING: Vitals at baseline, every 30 minutes during infusion, and at completion of infusion.
SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 30 minutes after infusion is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions.

Provider Signature: ____ Date: ________________________
Print name: _______________________________________ Phone # _________________ Fax # ________________________

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

RITUXIMAB & RITUXIMAB BIOSIMILARS

Yakima Memorial Hospital