

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800
Please mark the appropriate infusion center:

- | | |
|---|---|
| <input type="checkbox"/> Allenmore Infusion Center | <input type="checkbox"/> DHEC Infusion Center |
| <input type="checkbox"/> Auburn Infusion Center | <input type="checkbox"/> North Spokane Infusion Center |
| <input type="checkbox"/> Gig Harbor Infusion Services | <input type="checkbox"/> North Star Lodge Infusion Center |
| <input type="checkbox"/> Puyallup Infusion Center | |

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Rituximab (Rituxan) or other biosimilar

Patient Name: _____ Requested Date of Service: ____/____/____
Date of Birth: ____/____/____ Patient Phone Number: (____) _____ - _____ May leave message

- Diagnosis:**
- | | |
|---|--------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> _____ |

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs (patient height and weight are required for BSA dosing)
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required:

- CBC/CMP
- Hepatitis B screening prior to initiation of rituximab therapy. Patients that test positive for HBV surface antigen must be evaluated/treated for Hepatitis B before receiving rituximab

Maintenance labs required:

- CBC every 3 months - Hold infusion and notify provider for ANC <1000 and/or platelets <100k

IV Access: Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Patient weight _____ height _____ BSA _____ (required for BSA dosing)

Treatment Regimen (pharmacist to add MHS or insurance preferred product):

- Rituximab for RA: Rituximab 1000 mg or _____ mg IV on days 1 & 15 every 6 months x 1 year
- Pre-meds given 30 minutes prior to rituximab:
- Methylprednisolone 125 mg IV x 1 dose
 - Acetaminophen 650 mg po x 1 dose
 - Diphenhydramine 25 mg po x 1 dose or loratadine 10 mg po x 1 dose if intolerant to diphenhydramine
- Rituximab for GPA and MPA: 375 mg/m2 or _____ mg IV every week x 4 doses
- Pre-meds given 30 minutes prior to rituximab:
- Acetaminophen 650 mg po x 1 dose
 - Diphenhydramine 25 mg po x 1 dose or loratadine 10 mg po x 1 dose if intolerant to diphenhydramine

Rituximab infusion will be titrated per pharmacy protocol

Vital Signs: Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, 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.

Was consent obtained: Yes No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature _____ Print Name _____ Date _____ Time _____

Another brand of drug, identical in form and content, may be dispensed unless checked Orders expire in 12 months**

Patient Identification - Always Attach Patient Label

Name: _____
MRN #: _____
CSN #: _____
Age / Sex and Gender: _____

Pre-printed Order
RITUXIMAB (Rituxan) INFUSION

