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:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge 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:

- ❑ Rheumatoid Arthritis
- ❑ Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA)
- ❑ Other_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____

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 futher 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

MultiCare

78-0025-7MR (Rev. 9/24)