MHS Home/Alternate Site Infusion Services
Rituximab or Biosimilar Infusion Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name:	**DOB:** _____/_____/_____	**Weight:** _____ lb/kg
Patient Phone Number: (_____) _____-_____	**Requested Date of Service:** _____/_____/_____	

Patient Allergies:

Diagnosis: _____ **ICD – 10 Code:** _____

- Z45.2: Encounter for adjustment and management of vascular access device
- Z95.828: Presence of other vascular implants and grafts

Baseline Labs *(Required)***:**

- CBC/CMP Date: _____/_____/_____ Result: _____
- HBV screening Date: _____/_____/_____ Result: _____

Maintenance Labs:
CBC every 3 months; hold infusion and notify provider for ANC < 1000 and/or platelets < 100k

Lab Orders: _____

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider _____ (required) ****

Provider Order for Rituximab or Biosimilar Infusion

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.

Pre-Medication(s):

- ☐ Methylprednisolone: 125 mg IV once, 30 minutes prior to infusion **(for Rheumatoid Arthritis indication only)**
- ☐ Acetaminophen: 650 mg tab/cap by mouth once, 30 minutes prior to infusion *(patient may provide own supply)*
- ☐ Diphenhydramine: 25 mg tab/cap by mouth once, 30 minutes prior to infusion *(patient may provide own supply)* **OR**
- ☐ Loratadine: 10 mg tab/cap by mouth once, 30 minutes prior to infusion *(patient may provide own supply)*
- ☐ Famotidine 20 mg diluted in 5-10 mg NS IV once, 30 minutes prior to infusion
- ☐ Other: _____

Biologic Infusion:
Rituximab or Biosimilar added to appropriate volume of NS to achieve a final concentration of 1-4 mg/mL
(Pharmacy will dispense MultiCare or insurance preferred product)

Weight: _____kg Height: _____ BSA: _____ (required for BSA dosing)

Dose: Infuse _____mg via infusion pump. (Pharmacy will round dose to nearest vial size):

- ☐ 1000 mg Days 1 and 15 every 6 months (Rheumatoid Arthritis)
- ☐ 375 mg/m^2 every week x 4 doses (Granulomatosis with Polyangiitis/Microscopic Polyangiitis)
- ☐ Other _____

- First infusion: Start at 50 mg/hr, then increase in increments of 50 mg/hr every 30 min to a max of 400 mg/hr if no reaction.
- Subsequent Infusions: Pharmacist will adjust infusion rate based on patient response.

Additional Medications:

- 0.9% NaCl (NS) PF flush in 10 mL syringe: Administer 5 – 30 mL IV as needed for establishing and maintaining IV access and for flushing IV line post infusion.
- Heparin: 100 units/mL for port OR 10 units/mL for other central line/midline, 3-5 mL as needed for de-accessing line.
- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion.
- Diphenhydramine 25 mg IV once, as needed for itching.
- Acetaminophen 325-650 mg tab/cap by mouth once, as needed for pain.

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Skilled Nurse Interventions:

- Admit *(first visit)* patient to services for home infusion therapy of Rituximab or Biosimilar.
- Complete Skilled Nurse visit with each infusion for ongoing home infusion therapy of Rituximab or Biosimilar.
- Obtain vital signs (TPR & B/P) at baseline, with each infusion rate titration, and at completion of infusion.
- Obtain patient weight at each visit.
- Establish IV access and flush per policy to maintain patency.
- Draw labs as ordered.
- Administer pre-medications as prescribed.
- Add Rituximab or Biosimilar to appropriate volume of sodium chloride 0.9% (NS).
- Infuse Rituximab or Biosimilar as prescribed, at the rate determined by the pharmacist.
- Once infusion complete, flush IV line with sodium chloride 0.9% (NS) as prescribed.
- If vital signs are stable after infusion, Skilled Nurse will discontinue IV access and complete visit.

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):
The Skilled Nurse will:

- STOP THE INFUSION.
- Administer emergency medications as prescribed (*below*).
- For mild infusion reaction, may restart the infusion at a slower rate (verified with pharmacist) if symptoms resolve with medication.
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available. Max dose = 50 mg
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

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)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ **Printed Name:** _____ **Date:** _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:	**Return completed orders to:**
Address: _____	MultiCare Home/Alternate Site Infusion Services
Phone #: _____ Fax#: _____	253-459-6650 (*phone*) / 253-864-2785 (*fax*)

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:	Pre-printed order – Page 2 of 2
Name:	Rituximab or Biosimilar Order Set
MRN:	MultiCare Revised 10/24
DOB:	