Oregon Medical Group Infusion Center

1007 Harlow Road, Springfield, Oregon 97477
Phone: 541-741-0387 Fax: 541-242-4634

Rituximab (Ruxience, Truxima, Rituxan) Orders

Name: ___________________________________ DOB: ___________________________

Diagnosis/Indication: _________________________ ICD-10 Code: ______________________

Weight: __________________ Height: __________ BSA:____________________________

Please check product(s) willing to prescribe/order: If insurance allows, preferred medication is Ruxience, followed by Truxima, followed by Rituxan
☐ Rituximab-pvvr (Ruxience)
☐ Rituximab-abbs (Truxima)
☐ Rituximab (Rituxan). If only selecting Rituxan, please indicate reason for medical necessity:
____

☐ Infuse Rituximab 1000mg mixed with 0.9% Sodium Chloride for a total volume of 500 mL. Follow pharmaceutical protocol for drip rate guidelines.

☐ Infuse Rituximab mixed with 0.9% Sodium Chloride for a total volume of 500 mL per pharmaceutical protocol for drip rate guidelines as calculated below:

BSA _________X 375mg/m^2= ___________mg (round to nearest 100mg) = ______________mg

☐ Infuse Rituximab _______mg mixed with 0.9% Sodium Chloride for a total volume of 500 mL. Follow pharmaceutical protocol for drip rate guidelines.

1. Frequency of Rituximab (select all that apply):
   ☐ Initial Dosing: Every 2 weeks x 2 doses (Day 1 and Day 15)
   ☐ Maintenance Dosing: Repeat rituximab on day 1 and day 15 every _____ weeks or every _____ months
   ☐ Other: ____

2. Peripheral IV site with saline lock, may use existing PICC line or port-a-cath if available.

3. Vital signs: Initial, Q 15-30 minutes, PRN

4. Pre-medications to be given 30 minutes prior to infusion
   ☐ OMG Protocol for Infusions Requiring Pre-Medication
   OR
   ☐ Administer the following routine pre-medications prior to each infusion
      ☐ Acetaminophen (Tylenol) 650 mg PO
      ☐ Antihistamine (Select one)
         ☐ Diphenhydramine (Benadryl) 25 mg PO
         ☐ Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins
         ☐ Loratadine (Claritin) 10 mg PO
      ☐ Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min
      ☐ Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min
      ☐ Ondansetron 4 mg IV **OR** ☐ Ondansetron 8 mg IV
   ☐ Other: ____

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5. First infusion of each cycle starts @ 50mg/hr. Increase rate by 50mg/hr if no hypersensitivity reaction observed, every 30 minutes. Maximum infusion rate is 400mg/hr. If no hypersensitivity reaction during first infusion, subsequent infusions in same cycle may be started @ 100mg/hr. Increase rate 100mg/hr every 30 minutes to a maximum infusion rate of 400mg/hr.

6. For infusion reaction (**Must select one to be considered a complete order**)
   ☐ Acute Infusion Reaction Protocol
   ☐ Other ____

Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order (non-OMG providers). If a patient is high risk for TB exposure, a Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order (non-OMG providers).

Provider Signature: ______________________________________ Date: ____________
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: ___________________________________Time: ___________

Patient Name: ____DOB: ___________