

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Last Infusion: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Infusion Location: (state and Site) \_\_\_\_\_

## Rituxan® (rituximab) and biosimilars Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Non-Hodgkin's Lymphoma	_____ Chronic Lymphocytic Leukemia
_____ Rheumatoid Arthritis	
_____ OTHER:	

### Nursing Orders:

- Hold infusion and notify provider for:
  - Signs/symptoms of infection, planned/recent surgical procedures, recent live vaccines, new/worsening neurological or mood changes.
- If an infusion-related reaction occurs, stop infusion and initiate Hypersensitivity Reaction Management Protocol as clinically indicated.

### Prior to Infusion:

- ☐ Must have Hep B results
- ☐ Must have CBC with diff and platelets
- ☐ Must have renal function

Pre-medications (to be administered once 30 minutes prior to infusion):

<input type="checkbox"/> Tylenol 500 mg PO	<input type="checkbox"/> Solu-Medrol 125 mg IVP	<input type="checkbox"/> Loratadine 10 mg PO
<input type="checkbox"/> Benadryl 25 mg PO	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

### Dosing:

<input type="checkbox"/> Administer rituximab _____ mg
<input type="checkbox"/> Rituximab _____ mg/m <sup>2</sup> x (current BSA) _____ m <sup>2</sup> = _____ mg
<input type="checkbox"/> To PROHIBIT dose rounding, check here (Dose will be rounded by up to 10% to nearest 100 mg per protocol)
Doses less than 500mg go in final volume 250ml ml NS, Doses greater than 500 mg go in final volume 500 ml NS

### Dosing Schedule:

<input type="checkbox"/> Infuse on Day 0 and Day 14	<input type="checkbox"/> Infuse on Day 0, Day 7, Day 14 and Day 21
<input type="checkbox"/> Other:	

### Frequency:

<input type="checkbox"/> Repeat dosing in _____ weeks	<input type="checkbox"/> Repeat dosing in _____ months
<input type="checkbox"/> Other:	

Titrate infusion rates as follows (rates below calculated based on 1000 mg/500 ml concentration):

Hour	Initial Infusion		Subsequent Infusions (if previously tolerated)	
0	25 ml	50 mg/hr	50 ml	100 mg/hr
0.5	50 ml	100 mg/hr	100 ml	200 mg/hr
1	75 ml	150 mg/hr	150 ml	300 mg/hr
1.5	100 ml	200 mg/hr	200 ml	400 mg/hr

Provider name (print) \_\_\_\_\_ Date: \_\_\_\_\_

Provider signature: \_\_\_\_\_ Time: \_\_\_\_\_

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2	125 ml	250 mg/hr		
2.5	150 ml	300 mg/hr		
3	175 ml	350 mg/hr		
3.5	200 ml	400 mg/hr		
<b><u>Vital signs:</u></b> Pre-infusion, then with each rate change (at least every 30 minutes) until complete				

Lab orders:

- ☐ CBC with diff. (Frequency) \_\_\_\_\_
- ☐ Renal function (frequency) \_\_\_\_\_

Provider name (print) \_\_\_\_\_ Date: \_\_\_\_\_

Provider signature: \_\_\_\_\_ Time: \_\_\_\_\_