LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order RITUXIMAB (RUXIENCE) FOR NON-ONCOLOGY INDICATIONS	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

Anticipated Start Date: _____ **Patient to follow up with provider on date:** _____
*****This plan will expire after 365 days, unless otherwise specified below*****
Orders expire: _____

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis: _____ **Diagnosis Code:** _____

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.**
2. Hepatitis B (Hep B surface antigen and core antibody) screening must be completed prior to initiation of therapy and the patient should not be infected

PRE-SCREENING: (Results must be available prior to initiation of therapy)

- Hepatitis B Surface AG, Result Date: _____ ☐ Positive / ☐ Negative
- Hepatitis B Core AB Qual, Result Date: _____ ☐ Positive / ☐ Negative

LABS TO BE DRAWN (orders must be placed in TVC Epic by ordering provider if TVC provider):

☐ Complete Metabolic Set, Routine, every _____(visit)(days)(weeks)(months) - **Circle one**
☐ CBC with differential, Routine, every _____(visit)(days)(weeks)(months) - **Circle one**
☐ Other: _____

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

☐ acetaminophen (TYLENOL) tablet, oral, every visit
  ☐ 650 mg
  ☐ 325 mg
  ☐ Other: _____
☐ diphenhydrAMINE (BENADRYL) tablet, oral, every visit
  ☐ 25 mg
  ☐ 50 mg
☐ cetirizine (ZYRTEC) tablet, oral, every visit ***(Choose as alternative to diphenhydramine, if needed)***
  ☐ 10 mg
☐ methylPREDNISolone sodium succinate (SOLU-MEDROL) IV, every visit
  ☐ 125 mg
  ☐ 62.5 mg
  ☐ 40 mg

LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order RITUXIMAB (RUXIENCE) FOR NON-ONCOLOGY INDICATIONS	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):
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MEDICATIONS: (must check one):

Dose: (Pharmacist will use most recent weight at initiation and round dose to the nearest whole vial)

☐ **riTUXimab-pvvr (RUXIENCE) 375 mg/m2** = _____ **mg IV in NaCl 0.9%** to a final concentration of 2 mg/mL. First infusion or prior infusion reactions: start at 50 mg/hr x 30 min, then may increase by 50 mg/hr every 30 minutes if tolerated (NTE 400 mg/hr). Subsequent infusions if no reactions infuse rituximab at 100 mg/hr for the first 30 min. If no infusion related reactions are seen, increase rate by 100 mg/hour every 30 minutes to a maximum of 400 mg/hr

☐ **riTUXimab-pvvr (RUXIENCE)** _____ **mg IV in NaCl 0.9%** to a final concentration 2 mg/mL. First infusion or prior infusion reactions: start at 50 mg/hr x 30 min, then may increase by 50 mg/hr every 30 minutes if tolerated (NTE 400 mg/hr). Subsequent infusions if no reactions infuse rituximab at 100 mg/hr for the first 30 min. If no infusion related reactions are seen, increase rate by 100 mg/hour every 30 minutes to a maximum of 400 mg/hr

Interval:

☐ Once
☐ Every 2 weeks x 2 doses
☐ Every _____ weeks x _____ doses
☐ Weekly x 4 doses
☐ Other _____

AS NEEDED MEDICATIONS:

- acetaminophen 650 mg oral, EVERY 4 HOURS AS NEEDED for fever, headache or pain
- diphenhydrAMINE 25 mg oral, EVERY 4 HOURS AS NEEDED for itching
- meperidine 25-50 mg IV, EVERY 2 HOURS AS NEEDED (NTE 50 mg/hr) for rigors in the absence of hypotension

NURSING ORDERS (TREATMENT PARAMETERS):

1. Vital signs, every visit: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
2. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters.
3. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606.

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HYPERSENSITIVITY MEDICATIONS: Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients

1. hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
2. diphenhydrAMINE 25-50 mg IV, EVERY 2 HOURS AS NEEDED for hypersensitivity reaction (Max dose: 50 mg)
3. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. EPINEPHrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. naloxone (Narcan) 0.4 mg IV, AS NEEDED x1 dose for diminished respiratory rate
6. sodium chloride 0.9% 1000 mL IV, AS NEEDED x 1 dose for alteration in hemodynamic status
7. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction.

Please check the appropriate box for the patient's preferred clinic location:

☐ **Legacy Day Treatment Unit – The Vancouver Clinic Building**
A department of Salmon Creek Medical Center
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Emanuel Day Treatment Unit**
A department of Emanuel Medical Center
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

☐ **Legacy Salmon Creek Day Treatment Unit**
Legacy Salmon Creek Medical Center
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy STEPS Clinic**
A department of Silverton Medical Center
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

Organization/Department: _____