Legacy Day Treatment Unit  
Provider’s Orders

Adult Ambulatory Infusion Order
RITUXIMAB (RITUXAN)
FOR NON-ONCOLOGY INDICATIONS

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

Last updated 04/22/2020
**MEDICATIONS:** (must check one):

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

- **rituximab (RITUXAN) 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 (RITUXAN) _________ 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
- meperidene 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.
**Legacy Day Treatment Unit**

**Provider’s Orders**

Adult Ambulatory Infusion Order
RITUXIMAB (RITUXAN) FOR NON-ONCOLOGY INDICATIONS

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td>Med. Rec. No (TVC MRN Only):</td>
<td></td>
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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 x 1 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 x 1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x 1 dose for hypersensitivity reaction
5. naloxone (Narcan) 0.4 mg IV, AS NEEDED x 1 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**
  700 NE 87th Avenue, Suite 360
  Vancouver, WA 98664
  Phone number: 360-896-7070
  Fax number: 360-487-5773

- **Legacy Silverton STEPS Clinic**
  Legacy Silverton Medical Center
  342 Fairview Street
  Silverton, OR 97381
  Phone number: 503-873-1670
  Fax number: 503-874-2483

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

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

**Provider signature:** ____________________________  **Date/Time:** ____________________________

**Printed Name:** ____________________________  **Phone:** ______________  **Fax:** ______________

**Organization/Department:** ____________________________

Last updated 04/22/2020