Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

RiTUXimab Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. 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.
3. If patient is at 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). If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. Patient should have regular monitoring for hepatitis B, infection, and renal dysfunction.

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

- ☐ Hepatitis B surface antigen and core antibody total test results scanned with orders.
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders if patient is at high risk for TB exposure.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.
- ☐ TB screening is not necessary. Patient is not at high risk for TB exposure.

LABS:

- ☐ CBC with differential, Routine, ONCE, every (visit)(days)(weeks)(months) – *Circle One*
- ☐ Liver Set (AST, ALT, BILI TOTAL, BILI DIRECT, ALK PHOS, ALB, PROT TOTAL), Routine, ONCE, every (visit)(days)(weeks)(months) – *Circle One*
- ☐ IGG, SERUM, Routine, ONCE, every (visit)(days)(weeks)(months) – *Circle One*

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. **First infusion or prior infusion reactions**: infuse riTUXimab via pump (no additional filter is required) slowly at 50 mg/hr for the first hour. If no infusion related reactions are seen, increase rate gradually by 50 mg/hr every 30 minutes to a maximum of 400 mg/hr.
3. **Subsequent infusions**: infuse riTUXimab via pump at 100 mg/hr for the first hour. If no infusion related reactions are seen, increase rate gradually by 100 mg/hour every 30 minutes to a maximum of 400 mg/hour as tolerated.

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4. NURSING COMMUNICATION – HYPERSENSITIVITY/INFUSION REACTION #1 -- Monitor patient for riTUXimab infusion related reactions for 1 hour (first infusion) or 30 minutes (second infusion) after completion of riTUXimab infusion. Monitoring not required for third infusion and beyond, if no previous infusion reactions. Lengthened monitoring recommended for previous infusion reactions, contact provider for guidance.
5. VITAL SIGNS -- First infusion: During riTUXimab infusion obtain vital signs at baseline, then every 15 minutes for the first hour, then every 30 minutes with rate escalation, then every hour for the duration of the infusion.
6. VITAL SIGNS -- Subsequent infusions: During riTUXimab infusion obtain vital signs at baseline, then every 30 minutes with rate escalation, then every hour for the duration of the infusion.
7. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

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

- acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- methylPREDNISolone sodium succinate (SOLU-MEDROL), 125 mg, intravenous, ONCE, every visit

Biosimilar selection (must check one) – applies to all orders below

- ☐ TRUXIMA (riTUXimab-abbs) ***(OHSU & HMC preferred brand)***
- ☐ RITUXAN (riTUXimab) ***(Adventist preferred brand)***
- ☐ RUXIENCE (riTUXimab-pvvr)
- ☐ _____

At OHSU clinics, if insurance requires a different biosimilar agent, pharmacy will update the order per CDTM.

- ☐ Only check this box if it is NOT okay to substitute for insurance. Dispense as written (DAW).

MEDICATIONS:

riTUXimab 1000 mg in sodium chloride 0.9%, intravenous, ONCE, Infuse per nursing order.

Interval: ***(must check one)***

- ☐ Once
- ☐ Initial Dosing: Every 2 weeks x 2 doses
- ☐ Maintenance Dosing: Once every 26 weeks (6 months) after treatment initiation
- ☐ Every _____ weeks x _____ doses

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT- 133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose, for hypersensitivity or infusion reaction
6. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for infusion related fever
7. meperidine (DEMEROL) injection, 25-50 mg, intravenous, EVERY 2 HOURS AS NEEDED for infusion-related severe rigors in the absence of hypotension, not to exceed 50 mg/hr
8. sodium chloride 0.9% solution, 1000 mL, intravenous, AS NEEDED, Infuse at 200 mL/hr when infusion is stopped for emergency or PRN medications

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

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

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

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

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756