LIFEBRIDGE HEALTH
CARE BRAVELY

# RITUXIMAB-xxxx (Rituxan®/Truxima®/Ruxience®) IV FOR NON-ONCOLOGY INDICATIONS ORDER FORM

Patient Label

Date: _____

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____ Height: _____

Allergies: _____ Weight: _____

**Pre-appointment Documentation:**
Please fax most recent office visit note documenting the patient's diagnosis as well as a copy of the patient's demographic information along with this order form.

***Rituximab-xxxx may cause viral reactivation, cardiac conduction abnormalities, and progressive multifocal leukoencephalopathy (PML). Baseline assessment of HIV/HBV/hepatitis B/hepatitis C/TB status are recommended prior to start of therapy. Brain MRI and lumbar puncture are recommended in patients where PML is suspected.***

**Pre-appointment Lab Results:**
Complete blood counts with differential and platelet counts should be obtained prior to first infusion, at two to four-month intervals during therapy, and after final dose until resolution.

**Treatment:**

☐ **Premedication(s)** – *please check all premedication(s) desired for treatment*
- ☐ Acetaminophen 650mg PO once
- ☐ Diphenhydramine **25mg** or **50mg** **PO** or **IV** once *(will use 25mg PO if dose/route not indicated)*
- ☐ Methylprednisolone 125mg IV push once
- ☐ Other: _____

******Unless dictated by insurance, rituximab-abbs (Truxima®) or rituximab-pvvr (Ruxience®) will be drug of choice.******

☐ Rituximab-xxxx 500-1,000mg (fixed dose) IV in NS (final concentration 1 to 4mg/mL), infusion rate titrated per protocol.

Circle desired dose:

- ☐ Rituximab/rituximab-xxxx **500mg** or **1,000mg** in NS IV every 2 weeks x 2 doses
- ☐ Rituximab/rituximab-xxxx **500mg** or **1,000mg** in NS IV every 2 weeks x 2 doses, then every _____ month(s) x _____ doses
- ☐ Rituximab/rituximab-xxxx **500mg** or **1,000mg** in NS IV every _____ month(s) x _____ doses

☐ Rituximab-xxxx 375mg/m$^2$ in NS (final concentration 1 to 4mg/mL), infusion rate titrated per protocol

- ☐ Rituximab/rituximab-xxxx _____mg (round to nearest 100mg) in NS IV once
- ☐ Rituximab/rituximab-xxxx _____mg (round to nearest 100mg) in NS IV weekly x _____ doses
- ☐ Rituximab/rituximab-xxxx _____mg (round to nearest 100mg) in NS IV every 2 weeks x _____ doses

☒ **Hypersensitivity/Anaphylaxis Medications and Extravasation Management (PRN):** Follow Adult Hypersensitivity Protocol as needed per Nursing Protocol for the treatment of allergic/hypersensitivity reaction. Follow established hospital protocol for extravasation.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

**SINAI HOSPITAL**
**FAX TO:** 410-601-4452
410-601-9311
**PHONE**: 410-601-4779

**Wm. E. KAHLERT CANCER CENTER**
**(CARROLL HOSPITAL)**
**FAX TO**: 410-871-6521
**PHONE**: 410-871-6400