LIFEBRIDGE HEALTH
CARE BRAVELY

RITUXIMAB-xxxx
FOR NON-ONCOLOGY INDICATIONS
ORDER FORM

Patient Name: ______________________________ DOB: ______________

Allergies: ______________________________ Height (cm) : __________ Weight (kg) : __________

Diagnosis: ______________________________ Diagnosis Code: ______________

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Financial authorizations require clinical documentation of medical necessity. To ensure compliance, the criteria below must be indicated as completed by office representative. Incomplete documentation will be returned to the referring office for completion, resulting in delays to the patient receiving treatment.

- ☐ Ordering provider is credentialed at Sinai Hospital (Alvin and Lois Lapidus Cancer Center) or Carroll Hospital (William E. Kahlert Regional Cancer Center) to admit and write orders.
- ☐ Demographics / insurance information attached, or available in Cerner.
- ☐ Provider note dated within 30 days indicating medical need attached, or date if available in Cerner: ______________
- ☐ Baseline hepatitis panel completed and results attached, or date if available in Cerner: ______________

Treatment:

Premedication(s) – *please check all premedication(s) desired for treatment*

- ☐ Acetaminophen 650 mg PO once
- ☐ Diphenhydramine **25 mg** or **50 mg** **PO** or **IV** once *(will use 25 mg PO if dose/route not indicated)*
- ☐ Methylprednisolone 125 mg IV push once
- ☐ Other: ______________________________

******Unless dictated by insurance, rituximab-abbs (Truxima®) will be the biosimilar/product of choice.******

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

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

OR

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

- ☐ Rituximab-xxxx ________________mg (round to nearest 100 mg) in NS IV once
- ☐ Rituximab-xxxx ________________mg (round to nearest 100 mg) in NS IV weekly x ________________ doses
- ☐ Rituximab-xxxx ________________mg (round to nearest 100 mg) in NS IV every 2 weeks x ________________ doses

Rituximab-xxxx titration protocol:

- Initial infusion: Start infusion at 50 mg/hour, increase by 50 mg/hour every 30 minutes, to a maximum of 400 mg/hour as tolerated.
- Subsequent infusion(s): Start infusion at 100 mg/hour, increase by 100 mg/hour every 30 minutes, to a maximum rate of 400 mg/hour.

Protocol Orders:

- ☒ Hypersensitivity/Anaphylaxis Medications: Follow Adult Hypersensitivity Nursing Protocol PRN for the treatment of allergic/hypersensitivity reaction.
- ☒ Extravasation Management: Follow established protocol for extravasation as needed.
- ☒ Port Care and Flush per Nursing Protocol: Single-lumen flush protocol or double-lumen flush protocol as appropriate.

Physician's Name (Print): ______________________________ Signature: ______________________________ Date: __________

Contact Number: ______________________________ Fax Number: ______________________________

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(06/26)