Aultman Infusion Services 2600 Sixth St. SW Canton, OH 44714
Ph 330-363-1410 Fax 330-363-2380

Infusion Order – Rituximab

Name: _____ **DOB:** _____
Address: _____ **City:**_____ **State:** _____**Zip:** _____
Diagnosis: _____ **ICD-10:** _____
Allergies: _____

Weight _____ Kg **Height** _____ cm **BSA** _____ m2

Treatment regimen

- **Please check each of the following pre-medications that apply:**
  - ☐ **Acetaminophen** _____ mg po
  - ☐ **Diphenhydramine** _____ mg ☐ **po** ☐ **IV push**
  - ☐ **Methylprednisolone** _____ mg IV push
  - ☐ **Other** _____
- **Dispense the following rituximab product:** ☐ **Truxima** ☐ **Riabni** ☐ **Ruxience** ☐ **Rituxan**
  - ☐ **Rituximab 375mg/m2 x** _____ **m2 =** _____ **mg in 250 mL 0.9% NaCl IVPB -** Dose rounded to the nearest full vial size - _____**mg**
  - ☐ **Rituximab** _____**mg (500mg or 1000mg) in 500 mL 0.9% NaCl IVPB**
    - **First infusion:** Initiate infusion at 50mg/hr and, if infusion reactions do not occur, increase rate by 50mg/hr increments every 30 minutes, to a max of 400mg/hr
    - **Subsequent infusion:** Initiate infusion at 100mg/hr and, if infusion reactions do not occur, increase rate by 100mg/hr increments every 30 minutes, to a max of 400mg/hr
- **Flush IV line with 30-50mL 0.9% NaCl following completion of rituximab infusion**
- **Flush IV line using 10mL 0.9% NaCl flushes for IV start and as required** (and 5mL heparin 100units/mL for PICC/Port)
- **Please check one of the following frequencies**
  - ☐ Administer every _____ week(s) for _____ doses
  - ☐ Administer every _____ week(s) for _____ doses, then every _____
  - ☐ Administer on day 1 and 15 every _____ weeks (usual every 24 weeks, but no sooner than every 16 weeks)
  - ☐ Other _____
- Observe patient for at least 30 minutes following the completion of the first infusion for possible infusion-related reactions

Duration of Order: 1 year (unless otherwise specified: _____)

Rescue medications to be given for anaphylactic reactions (patients >40kg):

- **Epinephrine** 1:1000, 0.3mg (0.3mL) IM x 1, may repeat every 5-15 minutes x 2 doses (or sooner if clinically indicated) if the patient does not respond.
- **Diphenhydramine** 50mg IV Push x 1 over 2 minutes
- **Sodium Chloride 0.9% 250mL** IV x 1 at 250mL/hour

Additional orders_____

Physician Signature: _____**Print:**_____

Date: _____ **Phone:** _____ **Fax:** _____