# Rituxan Order

CURBSIDE INFUSION SERVICES

**Patient Information:**

- **Patient Name:** _____
- **Date of Birth:**_____
- **Height:** _____ ◯ cm ◉ in
- **Weight:** _____ ◯ kg ◉ lbs
- **Allergies:** _____
- **Diagnosis (ICD-10 Code**): _____
- **Current Medications:** (Attach most recent medication list)
- **Female Patients of Childbearing Potential:**
  - Is the patient pregnant or planning to become pregnant? ◯ Yes ◯ No
  - Effective contraception is required during treatment and for 12 months after last dose. Patient educated? ◯ Yes ◉ No (Initial: )
  - Patient breastfeeding? ◯ Yes ◯ No (Should not breastfeed during treatment and for 6 months after last dose.)

**Prescriber Information:**

- **Prescriber Name:** _____
- **NPI #:** _____
- **Phone**: _____ **Fax:** _____
- **Date of Order:**_____

**Rituxan (Rituximab) Infusion Order:**

- **Drug:** Rituximab (Rituxan) or Rituximab Biosimilar (e.g., Riabni, Ruxience, Truxima)
  - ☐ **May substitute mandated or preferred biosimilar as necessary.**
- **Dose:**
  - ◯ Rituximab_____mg IV (calculated as _____ mg/m²)
  - ◉ Rituximab _____ mg IV (flat dose)
- **Dilution:**
  - Dilute in 500 mL of 0.9% Sodium Chloride (NS) or 5% Dextrose in Water (D5W) for doses 500 mg or less and 1000 mL for doses 500 mg or more for a final concentration of 1-4 mg/mL.
- **Frequency/Schedule:** (Check all that apply)
  - ☐ One-time dose
  - ☐ Weekly x 4 weeks
  - ☐ Day 0, repeat dose in 2 weeks
  - ☐ Day 0, repeat dose in 2 weeks, then repeat course every 6 months (RA, PV)
  - ☐ Every _____ weeks OR ___ months x _____ cycles/months
  - ☐ Other (Specify): _____

**Pre-Treatment Medications:** (To be administered 30-60 minutes before EACH Rituxan infusion, unless otherwise specified)

- ☐ Acetaminophen (Tylenol) 650 mg PO x 1 dose
- ☐ Diphenhydramine (Benadryl) 25 mg / 50 mg (circle one) PO OR IV (circle one) x 1 dose
- ☐ Methylprednisolone (Solu-Medrol) 100 mg IVP x 1 dose (Recommended for RA, GPA, MPA, PV)
- ☐ Other (Please Specify): _____

**Infusion Rates:**

- **First Infusion:**
  - Initiate infusion at 50 mg/hour.
  - If tolerated, increase rate by 50 mg/hour every 30 minutes to a maximum of 400 mg/hour.
- **Subsequent Infusions:**
  - If the previous dose was tolerated, initiate at 100 mg/hour.
  - If tolerated, increase rate by 100 mg/hour every 30 minutes to a maximum of 400 mg/hour.
  - *If the previous dose was not tolerated, infuse per the initial dose rates.*
- **Lab Orders:**
  - **Before first infusion:**
    - ☐ Negative Hepatitis B Surface Antigen (HBsAg) and Hepatitis B Core Antibody (anti-HBc) within 3 years.
    - ☐ Complete Blood Count (CBC) with differential
    - ☐ Comprehensive Metabolic Panel (CMP)
    - ☐ Other: _____
  - **Before each dose / as clinically indicated:**
    - ☐ CBC with differential
    - ☐ CMP
    - ☐ Other: _____

**Physician Attestation & Signature:**

- I have reviewed the patient's medical history, current medications, and lab results.
- I confirm the patient has been screened for HBV, and any necessary prophylaxis/monitoring is in place.
- I confirm the patient has been educated on potential side effects and the need for contraception (if applicable).
- I order Rituxan infusion as detailed above, based on current clinical guidelines and patient need.

**Physician Signature:** _____
**Name:**_____ **Date:** _____