Ascension St. Vincent's Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Rituximab (Rituxan/Riabni/Ruxience/Truxima) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List:	_____

Diagnosis	**ICD 10 Code(s)**		**J Code***		**CPT Code**
☐ Rheumatoid Arthritis ☐ Other: _____	☐ M05.79 ☐ D69.3 ☐ G35	☐ G70 ☐ Other: _____	☐ Rituxan: J9312 ☐ Truxima: Q5115	☐ Ruxience: Q5119 ☐ Riabni: Q5123	☐ CPT Code: _____

Labs (prior to scheduling infusion)	**Other labs**
☑ TB Test, Hepatitis Panel, CBC, CRP, ESR, Immunoglobulin A, E, G, M	☐ _____

Nursing Orders	**Pre-medications**	
☑ Discharge patient when stable and meets protocol criteria	☑ Acetaminophen 975 mg PO, once ☑ Diphenhydramine 25 mg PO, once ☑ Dexamethasone 20 mg IV, once	☐ Diphenhydramine 25 mg IV, once ☐ Ondansetron 4 mg IV, once ☐ Cetirizine 10 mg PO, once ☐ Other: _____ ☐ Other: _____
Emergency/Anaphylaxis Order		
☑ Follow standard orders for management of allergies and anaphylaxis reactions		

Medication Orders

	Medication	**Route**	**Dose**	**Frequency**	**Select Treatment Type**
☐	Rituxan (rituximab)	IVPB	☐ 500 mg ☐ 1000 mg ☐ 375 mg/m^2	Once	☐ Induction: Every 2 weeks x 2 doses ☐ Maintenance: Every 2 weeks x 2 doses. Repeat every 24 weeks for ____ dose(s) ☐ Weekly for ____ dose(s) ☐ Every 3 months for ____ dose(s) ☐ Other: _____
☐	Riabni (rituximab-arrx)				
☐	Ruxience (rituximab-pvvr)				
☐	Truxima (rituximab-abbs)				

Order Comments: Start at 50mg/hr x 1 hr, then 100mg/hr x 30min. If SBP is within 20mmHg of baseline, pulse greater than 60 and less than 120, and temp < 38 C), then increase as follows: 150mg/hr x 30min → 200mg/hr x 30 min → 250mg/hr x 30 min → 300mg/hr x 30 min → 400mg/hr (max rate). If an infusion-related reaction occurs, slow or stop the infusion. If the reaction abates, restart infusion at 50% of the previous rate. Discontinue infusion in the event of serious or life-threatening cardiac arrhythmias. **Do NOT administer as a bolus or push.** Do NOT administer during an active or localized infection. Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol. ***Pharmacy may substitute a biosimilar based on insurance coverage.**

Infusion Center Staff Please fax infusion records or discharge summary to:	**Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			