Corewell Health™

Patient Name
DOB
MRN
Physician
CSN

Physician's Orders
RITUXIMAB OR BIOSIMILAR
WEEKLY TIMES 4 DOSES - ADULT, OUTPATIENT, INFUSION CENTER
Page 1 to 3

Anticipated Infusion Date_____ ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Site of Service

☐ CH Gerber ☐ CH Lemmen Holton (GR) ☐ CH Pennock ☐ CH Greenville
☐ CH Helen DeVos (GR) ☐ CH Ludington ☐ CH Reed City ☐ CH Zeeland
☐ CH Blodgett (GR)

Provider Specialty

☐ Allergy/Immunology ☐ Infectious Disease ☐ OB/GYN ☐ Rheumatology
☐ Cardiology ☐ Internal Med/Family Practice ☐ Other ☐ Surgery
☐ Gastroenterology ☐ Nephrology ☐ Otolaryngology ☐ Urology
☐ Genetics ☐ Neurology ☐ Pulmonary ☐ Wound Care

Treatment Intent

☐ Conditioning ☐ Curative ☐ Mobilization ☐ Supportive
☐ Control ☐ Maintenance ☐ Palliative

Cycle 1

One dose every 7 days x 4 doses on day 1, 8, 15, 22

Provider Reminder

◉ **ONC PROVIDER REMINDER 2**

Confirm that the appropriate informed consents have been signed and are in the medical record.

Appointment Requests

◉ **ONCBCN CALCULATED LENGTH INFUSION APPOINTMENT REQUEST 1**

Labs

◉ **COMPLETE BLOOD COUNT (CBC) W/DIFFERENTIAL**

▣ **Pregnancy tests recommended for Females aged 12 to 60 with Uterus intact.**

Please order as appropriate for clinical presentation
Interval: Once Selection conditions: Patient could become pregnant

◯ **HCG, QUANTITATIVE**

▣ **ONC PROVIDER REMINDER**

Review prior hepatitis labs and consider repeat screening as indicated.

▣ **HEPATITIS PANEL**

Selection conditions: Hides NCCN Hepatitis Screening orders in background if the patient has had a completed hepatitis lab within the last 365 days.

▣ **HEP B CORE TOTAL AB**

Selection conditions: Hides NCCN Hepatitis Screening orders in background if the patient has had a completed hepatitis lab within the last 365 days.

Vitals

◉ **VITAL SIGNS**

RITUXIMAB - Dose 1 & 2: Vital signs every 15 minutes x 2 hours, then hourly throughout infusion. Subsequent doses: Vital signs with rate changes.

Nursing Orders

◉ **HYPERSENSITIVITY REACTION ADULT ONCOLOGY PROTOCOL**

◉ **ONC NURSING COMMUNICATION 100**

May Initiate IV Catheter Patency Adult Protocol

CONTINUED ON PAGE 2 ➔

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

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Treatment Parameters

◉ **ONC MONITORING AND HOLD PARAMETERS 3**

May proceed with treatment if hepatitis B core antibody and surface antigen labs have been resulted prior to the first dose, and the results are negative.

Pre-Medications

◯ **acetaminophen (Tylenol) tablet 650 mg**

Dose: 650 mg Route: Oral Once Instructions: Administer 30 minutes prior to rituximab.

◯ **diphenhydrAMINE (Benadryl) capsule 50 mg**

Dose: 50 mg Route: Oral Once Instructions: Administer 30 minutes prior to rituximab.

Pre-Medications

◉ **ONC PROVIDER REMINDER 7**

HISTORY OF INFUSION REACTION: consider adding CORTICOSTEROID pre-medication prior to riTUXimab or biosimilar

◯ **dexAMETHasone (Decadron) injection 10 mg**

Dose: 10 mg Route: Intravenous Once over 5 Minutes for 1 dose
Instructions:
For patient with a history of reaction to riTUXimab or biosimilar. Administer 30 minutes prior to start of riTUXimab or biosimilar.

◯ **methylPREDNISolone sodium succinate (SOLU-Medrol) injection 125 mg**

Dose: 125 mg Route: Intravenous Once for 1 dose
Instructions:
For patient with a history of reaction to riTUXimab or biosimilar. Administer 30 minutes prior to start of riTUXimab or biosimilar.

◯ **hydrocortisone sodium succinate (PF) (Solu-CORTEF) injection 100 mg**

Dose: 100 mg Route: Intravenous Once for 1 dose
Instructions:
For patient with a history of reaction to riTUXimab or biosimilar. Administer 30 minutes prior to start of riTUXimab or biosimilar.

Monoclonal Antibody / Biotherapy

◉ **riTUXimab-pvvr (RUXIENCE) 2 mg/mL infusion 375 mg/m2**

Dose: 375 mg/m2 Route: Intravenous Titrate @ 25-200 mL/hr for 1 dose
Instructions:
Before start of riTUXimab-pvvr, infusion, prime 0.9% sodium chloride 250 mL with primary tubing and have available at bedside in case of hypersensitivity or infusion reaction. Do NOT connect this saline with any other intravenous drugs, fluids, or blood products.

Start infusion at 50 mg/hr (25 mL/hr). For patients tolerating the infusion well, the rate of infusion may be increased in increments of 50 mg/hr (25 mL/hr) at intervals of 30 minutes to a maximum rate of 400 mg/hr (200 mL/hr).

SUBSEQUENT INFUSIONS: If patient tolerated initial infusion, start at 100 mg/hour (50 mL/hr); if there is no infusion-related reaction, increase the rate by 100 mg/hour (50 mL/hr) increments every 30 minutes, to a maximum rate of 400 mg/hour (200 mL/hr)

◯ **riTUXimab-abbs (TRUXIMA) 2 mg/mL infusion 375 mg/m2**

Dose: 375 mg/m2 Route: Intravenous Titrate @ 25-200 mL/hr for 1 dose
Instructions:
Before start of riTUXimab-abbs, infusion, prime 0.9% sodium chloride 250 mL with primary tubing and have available at bedside in case of hypersensitivity or infusion reaction. Do NOT connect this saline with any other intravenous drugs, fluids, or blood products.

Start infusion at 50 mg/hr (25 mL/hr). For patients tolerating the infusion well, the rate of

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infusion may be increased in increments of 50 mg/hr (25 mL/hr) at intervals of 30 minutes to a maximum rate of 400 mg/hr (200 mL/hr).

SUBSEQUENT INFUSIONS: If patient tolerated initial infusion, start at 100 mg/hour (50 mL/hr); if there is no infusion-related reaction, increase the rate by 100 mg/hour (50 mL/hr) increments every 30 minutes, to a maximum rate of 400 mg/hour (200 mL/hr)

◯ **riTUXimab (RITUXAN) 2 mg/mL infusion 375 mg/m2**

Dose: 375 mg/m2 Route: Intravenous Titrate @ 25-200 mL/hr for 1 dose

Instructions:

Before start of riTUXimab, infusion, prime 0.9% sodium chloride 250 mL with primary tubing and have available at bedside in case of hypersensitivity or infusion reaction. Do NOT connect this saline with any other intravenous drugs, fluids, or blood products.

Start infusion at 50 mg/hr (25 mL/hr). For patients tolerating the infusion well, the rate of infusion may be increased in increments of 50 mg/hr (25 mL/hr) at intervals of 30 minutes to a maximum rate of 400 mg/hr (200 mL/hr).

SUBSEQUENT INFUSIONS: If patient tolerated initial infusion, start at 100 mg/hour (50 mL/hr); if there is no infusion-related reaction, increase the rate by 100 mg/hour (50 mL/hr) increments every 30 minutes, to a maximum rate of 400 mg/hour (200 mL/hr)

◯ **riTUXimab-arrx (RIABNI) 2 mg/mL infusion 375 mg/m2**

Dose: 375 mg/m2 Route: Intravenous Titrate @ 25-200 mL/hr for 1 dose

Instructions:

Before start of riTUXimab-arrx infusion, prime 0.9% sodium chloride 250 mL with primary tubing and have available at bedside in case of hypersensitivity or infusion reaction. Do NOT connect this saline with any other intravenous drugs, fluids, or blood products.

Start infusion at 50 mg/hr (25 mL/hr). For patients tolerating the infusion well, the rate of infusion may be increased in increments of 50 mg/hr (25 mL/hr) at intervals of 30 minutes to a maximum rate of 400 mg/hr (200 mL/hr).

SUBSEQUENT INFUSIONS: If patient tolerated initial infusion, start at 100 mg/hour (50 mL/hr); if there is no infusion-related reaction, increase the rate by 100 mg/hour (50 mL/hr) increments every 30 minutes, to a maximum rate of 400 mg/hour (200 mL/hr)

Supportive Care

◉ **prochlorperazine (COMPAZINE) tablet 10 mg**

Dose: 10 mg Route: Oral Every 6 hours PRN

Instructions: Use 1st line for nausea/vomiting for patients able to tolerate oral medications.

◉ **prochlorperazine (COMPAZINE) injection 10 mg**

Dose: 10 mg Route: Intravenous Every 6 hours PRN over 5 Minutes

Instructions: Use 1st line for nausea/vomiting for patients unable to tolerate oral medications.

◉ **ondansetron (ZOFRAN-ODT) disintegrating tablet 8 mg**

Dose: 8 mg Route: Oral Every 8 hours PRN

Instructions: Use 2nd line for Nausea/Vomiting. May give IV if unable to tolerate PO.

◉ **ondansetron (ZOFRAN) injection 8 mg**

Dose: 8 mg Route: Intravenous Every 8 hours PRN over 5 Minutes

Instructions: Use 2nd line for Nausea/Vomiting. May give IV if unable to tolerate PO.

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED: TIME	DATE	VALIDATED: TIME	DATE	ORDERED: TIME	DATE	Pager #
Sign		R.N. Sign		Physician Print		Physician Sign

EPIC VERSION DATE: 07/16/20

