

Patient Name _____
 DOB _____
 MRN _____
 Physician _____
 FIN _____

Anticipated Infusion Date _____ ICD 10 Code with Description _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Provider Specialty

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal Med/Family Practice | <input type="checkbox"/> Other | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Neurology | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Wound Care |

Site of Service

- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> SH Gerber | <input type="checkbox"/> SH Lemmen Holton (GR) | <input type="checkbox"/> SH Pennock | <input type="checkbox"/> SH United Memorial |
| <input type="checkbox"/> SH Helen DeVos (GR) | <input type="checkbox"/> SH Ludington | <input type="checkbox"/> SH Reed City | <input type="checkbox"/> SH Zeeland |

Treatment Intent

- | | | | |
|---------------------------------------|--------------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Conditioning | <input type="checkbox"/> Curative | <input type="checkbox"/> Mobilization | <input type="checkbox"/> Supportive |
| <input type="checkbox"/> Control | <input type="checkbox"/> Maintenance | <input type="checkbox"/> Palliative | |

Types: ONCOLOGY SUPPORTIVE CARE, ONCOLOGY SUPPORTIVE CARE 2, ONCOLOGY SUPPORTIVE CARE 3, NON-ONCOLOGY SUPPORTIVE CARE, Non-Oncology Supportive Care 2, Non-Oncology Supportive Care 3

Synonyms: NEPHROLOGY, RHEUMATOLOGY, RITUXAN, ITP, EVANS, HEMATOLOGY, RUXIENCE, TRUXIMA

Cycles 1 – 4		Cycle length: 7 days
Day 1		Perform every 1 day x1
Appointment Requests	<input checked="" type="radio"/> ONCBCN INFUSION APPOINTMENT REQUEST Interval: Once Occurrences: 1 Treatment Expected: S, Expires: S+365, No date restriction Tx labs, Chemo	
Provider Reminder	<input checked="" type="radio"/> ONC PROVIDER REMINDER 14 Interval: Until discontinued Occurrences: 1 Treatment Comments: Pretreatment with acetaminophen and an antihistamine is recommended. For symptoms of allergic reaction or anaphylaxis, order "Peds Hypersensitivity Reactions" Therapy Plan.	
Treatment Parameters	<input checked="" type="radio"/> RENAL FUNCTION PANEL Interval: STAT Occurrences: 1 Treatment Expected: S, Blood, Blood Central Line	
Treatment Parameters	<input checked="" type="radio"/> C3 COMPLEMENT Interval: STAT Occurrences: 1 Treatment Expected: S, Blood, Blood Central Line	
Treatment Parameters	<input checked="" type="radio"/> C4 COMPLEMENT Interval: STAT Occurrences: 1 Treatment Expected: S, Blood, Blood Central Line	

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CONTINUED ON PAGE 2 →

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



Treatment Parameters

COMPLETE BLOOD COUNT (CBC) W/MANUAL DIFF

Interval: STAT Occurrences: 1 Treatment
 Expected: S, Blood, Blood Central Line

Treatment Parameters

CD20 BY FLOW CYTOMETRY

Interval: STAT Occurrences: 1 Treatment
 Expected: S, Blood, Blood Central Line

Treatment Parameters

PROTEIN/CREAT RATIO, URINE

Interval: STAT Occurrences: 1 Treatment
 Expected: S, Blood, Blood Central Line

Treatment Parameters

RETICULOCYTE COUNT WITH RETICULOCYTE HEMOGLOBIN

Interval: STAT Occurrences: 1 Treatment
 Expected: S, Blood, Blood Central Line



Hydration

sodium chloride 0.9% (NS) infusion

Dose: 65 mL/m²/hr Route: Intravenous PRN for dehydration
 Start: S

Instructions:
 Infuse until start of Rituximab.

Monoclonal Antibody

ACETAMINOPHEN (TYLENOL), CHOOSE ONE:

acetaminophen (TYLENOL) tablet 15 mg/kg

Dose: 15 mg/kg Route: Oral Every 6 hours for 2 doses
 Start: S

Instructions:
 Administer 30 minutes prior to rituximab.
 Recommended maximum single dose is 1000 mg.
 No more than 5 doses from all sources in 24-hour period, not to exceed 4000 mg/day.

acetaminophen (TYLENOL) 32 MG/ML suspension 15 mg/kg

Dose: 15 mg/kg Route: Oral Every 6 hours for 2 doses
 Start: S

Instructions:
 Administer 30 minutes prior to rituximab.
 Recommended maximum single dose is 1000 mg.
 No more than 5 doses from all sources in 24-hour period, not to exceed 4000 mg/day.



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Monoclonal Antibody

DIPHENHYDRAMINE (BENADRYL), CHOOSE ONE:

diphenhydrAMINE (BENADRYL) injection 1 mg/kg

Dose: 1 mg/kg Route: Intravenous Every 6 hours for 2 doses
 Start: S

Instructions:
 Administer 30 minutes prior to rituximab.

Recommended maximum single dose is 50 mg.

diphenhydrAMINE (BENADRYL) 12.5 MG/5ML elixir 1 mg/kg

Dose: 1 mg/kg Route: Oral Every 6 hours for 2 doses
 Start: S

Instructions:
 Administer 30 minutes prior to rituximab.

Recommended maximum single dose is 50 mg.

diphenhydrAMINE (BENADRYL) capsule 1 mg/kg

Dose: 1 mg/kg Route: Oral Every 6 hours for 2 doses
 Start: S

Instructions:
 Administer 30 minutes prior to rituximab.

Recommended maximum single dose is 50 mg.



Monoclonal Antibody

methyIPREDNISolone sodium succinate (SOLU-Medrol) injection 0.5 mg/kg

Dose: 0.5 mg/kg Route: Intravenous Once over 30 Minutes for 1 dose
 Start: S

Instructions:
 Administer 30 minutes prior to rituximab.

Recommended maximum single dose is 1000 mg.

Refer to IV Push policy for maximum IV Push dose and rate. Do not administer doses greater than 125 mg by IV Push.

Monoclonal Antibody

ONC PROVIDER REMINDER 25

Interval: Until discontinued Occurrences: 1 Treatment

Comments: Ruxience is the Spectrum Health preferred product for rituximab. If insurance dictates, alternate products are available under suggested protocol orders. Go to actions, add orders and refer to the left side navigation pane.



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Monoclonal Antibody **Select Either riTUXimab-pvvr (RUXIENCE) (PREFERRED FORMULARY PRODUCT) Or riTUXimab (RITUXAN) Or riTUXimab-abbs (TRUXIMA).** Defer to insurance requirements for specific product covered. Proceed with administration based on coverage. If more than one is approved, will confirm with ordering provider.

riTUXimab-pvvr (RUXIENCE) 1 mg/mL chemo infusion (subsequent infusion) 375 mg/m²

Dose: 375 mg/m² Route: Intravenous Titrate for 1 dose
 Start: S

Base Solution:

- Sodium Chloride 0.9%
- Dextrose 5%

Instructions:

Hold hydration during infusion.

INITIAL DOSE INFUSION RATE: Start IV infusion at _____ mL/hour (0.5 mL/kg/hour, maximum rate 50 mL/hour) for 60 minutes. If patient tolerates without reaction, may escalate infusion rate by _____ mL/hour (0.5 mL/kg/hour, maximum 50 mL/hour) every 30 minutes up to a maximum rate of _____ mL/hour (4 mL/kg/hour, maximum 400 mL/hour).

SUBSEQUENT DOSE - STANDARD INFUSION RATE: Start IV infusion at _____ mL/hour (1 mL/kg/hour, maximum rate 100 mL/hour) for 60 minutes. If patient tolerates without reaction, may escalate infusion rate by _____ mL/hour (1 mL/kg/hour, maximum 100 mL/hour) every 30 minutes up to a maximum of _____ mL/hour (4 mL/kg/hour, maximum 400 mL/hour).

riTUXimab (RITUXAN) 1 mg/mL chemo infusion (subsequent infusion) 375 mg/m²

Dose: 375 mg/m² Route: Intravenous Titrate for 1 dose
 Start: S

Base Solution:

- Sodium Chloride 0.9%
- Dextrose 5%

Instructions:

Hold hydration during infusion.

INITIAL DOSE INFUSION RATE: Start IV infusion at _____ mL/hour (0.5 mL/kg/hour, maximum rate 50 mL/hour) for 60 minutes. If patient tolerates without reaction, may escalate infusion rate by _____ mL/hour (0.5 mL/kg/hour, maximum 50 mL/hour) every 30 minutes up to a maximum rate of _____ mL/hour (4 mL/kg/hour, maximum 400 mL/hour).

SUBSEQUENT DOSE - STANDARD INFUSION RATE: Start IV infusion at _____ mL/hour (1 mL/kg/hour, maximum rate 100 mL/hour) for 60 minutes. If patient tolerates without reaction, may escalate infusion rate by _____ mL/hour (1 mL/kg/hour, maximum 100 mL/hour) every 30 minutes up to a maximum of _____ mL/hour (4 mL/kg/hour, maximum 400 mL/hour).

riTUXimab-abbs (TRUXIMA) 1 mg/mL chemo infusion (subsequent infusion) 375 mg/m²

Dose: 375 mg/m² Route: Intravenous Titrate for 1 dose
 Start: S

Base Solution:

- Sodium Chloride 0.9%
- Dextrose 5%

Instructions:

Hold hydration during infusion.

INITIAL DOSE INFUSION RATE: Start IV infusion at _____ mL/hour (0.5 mL/kg/hour, maximum rate 50 mL/hour) for 60 minutes. If patient tolerates without reaction, may escalate infusion rate by _____ mL/hour (0.5 mL/kg/hour, maximum 50 mL/hour) every 30 minutes up to a maximum rate of _____ mL/hour (4 mL/kg/hour, maximum 400 mL/hour).

SUBSEQUENT DOSE - STANDARD INFUSION RATE: Start IV infusion at _____ mL/hour (1 mL/kg/hour, maximum rate 100 mL/hour) for 60 minutes. If patient tolerates without reaction, may escalate infusion rate by _____ mL/hour (1 mL/kg/hour, maximum 100 mL/hour) every 30 minutes up to a maximum of _____ mL/hour (4 mL/kg/hour, maximum 400 mL/hour).

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Nursing Orders

ONC NURSING COMMUNICATION 52

Interval: Until discontinued Occurrences: 1 Treatment
 Comments: Rituximab

- Obtain heart rate, respiratory rate, blood pressure and pulse oximetry and assess for symptoms of anaphylaxis every 15 minutes during drug infusion through 30 minutes after drug completion.
- Notify pediatric oncologist, NP or PA-C and stop infusion immediately if patient has itching, hives, swelling, fever, rigors, dyspnea, cough, or bronchospasm.
- Notify pediatric oncologist, NP or PA-C if greater than 20% decrease in systolic or diastolic blood pressure.
- Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.

Extravasation Guidelines

ONC NURSING COMMUNICATION 10

Interval: Until discontinued Occurrences: 1 Treatment
 Comments: 1. When an extravasation is suspected, stop the infusion. Disconnect the IV tubing, attach a syringe to the end of the catheter or butterfly and attempt to aspirate any residual drug from the site.
 2. Contact the attending provider. Use of pharmacologic antidotes remains controversial. The attending will determine if other pharmacologic treatments are appropriate.
 3. For more details about extravasation management refer to:
https://members.childrensoncologygroup.org/_files/disc/Nursing/ExtravasationReference.pdf (this link is available on the Springboard Report)
 4. Ensure patient/parent is educated about the extravasation and follow-up assessments.

Extravasation Guidelines

ONC NURSING COMMUNICATION 53

Interval: Until discontinued Occurrences: 1 Treatment
 Comments: Rituximab is not an irritant or vesicant and extravasation does not require any local care.

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

EPIC VERSION DATE: