TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

Rituxan® (Rituximab) Order Form

Return Completed Form
To: 888.898.9113

PATIENT INFORMATION

Patient Name:_____ Date:_____
Address:_____ Phone/Cell:_____
City, State, Zip: _____
DOB:_____ Weight:_____ Height:_____ B.S.A._____ Diabetic: ☐ Yes ☐ No
Diagnosis / ICD 10 Code: _____
Allergies: _____

☐ **RN to teach medication management**

PREMEDICATION ORDERS

☐ Acetaminophen 650 mg po 30 minutes prior to Rituxan **AND** q 4 hrs PRN temp >100.5
☐ Diphenhydramine 25 mg / 50 mg IV **-or-** po 30 minutes prior to Rituxan
☐ Methylprednisolene 100 mg IV 30 minutes prior to therapy
☐ **Other:**

INFUSION ORDERS

☐ Rituxan® _____mg IV (Dose = _____mg/m^2)
  ☐ Infuse weekly **x** _____doses
  ☐ Infuse on days 1 and 15

☐ Dilute Rituxan® to a final concentration of _____mg/mL (range: 1-4 mg/mL) with _____mL of Sodium Chloride 0.9%
  a) **First infusion**: Administer at an initial rate of 50 mg/hr Increase rate by 50 mg/hr q 30 minutes to a maximum rate of 400 mg/hr, as tolerated.
  b) **Subsequent infusions**: Administer at an initial rate of 100 mg/hr. Increase rate by 100 mg/hr q 30 minutes to a maxium rate of 400 mg/hr, as tolerated.

☐ Check and record vital signs q 5 minutes for first 15 minutes, q 15 minutes for next hour, q 30 minutes for next hour, and then Hourly for the remainder of infusion.
☐ Stop infusion for fever (T > 101.5), hypotension (↓ 30 mm/Hg from baseline), chills, rigors, dizziness, dyspnea or early signs of bronchospasm. (Notify MD. Keep vein open)
☐ After resolution of symptoms, infusion may be resumed at one-half of the previous rate and increased per above protocol.
☐ **Other:**

LAB ORDERS

☐ CBC w/diff and Platelets _____ ☐ CMP _____
☐ **Other:**

IV ACCESS

☐ Start PIV if no IV access available ☐ Maintain current central line access

CATHETER CARE

☐ Sodium Chloride 0.9% _____mL IV before **AND** after each IV access **AND** PRN per protocol.
☐ Sodium Chloride 0.9% _____mL as above **AND** Heparin 100 Units/mL_____mL IV flush after second saline flush **AND** PRN.
* Dressing changes weekly **AND** PRN * Biopatch dressing * May obtain blood from IV access for labs
* May use Cathflo 2mg/2mL sterile water IVP 1 mL per lumen; may repeat after 2 hours' x 1

GENERAL ADULT DOSING GUIDELINES FOR NON-NEOPLASTIC DIAGNOSES

☐ **Idiopathic Thrombocytopenic Purpura (ITP):** 375 mg/m^2 IV weekly **x** 4 weeks
☐ **Moderately – to severely – active Rheumatoid Arthritis:** 1000 mg on days 1 and 15
☐ **Severe Pemphigus:** 375 mg/m^2 IV weekly **x** 4 weeks

Prescribing Physician:_____ Address:_____ Phone: _____

PHYSICIAN'S SIGNATURE:_____ **DATE**: _____