riTUXimab-abbs (TRUXIMA) for Rheumatoid Arthritis

Weight: ___________kg   Height: ___________cm

Allergies: _____________________________________________________________

Diagnosis Code: ______________________________________________________

Treatment Start Date: ____________   Patient to follow up with provider on date: ____________

**This plan will expire after 365 days at which time a new order will need to be placed**

GUIDELINES FOR ORDERING
1. Send FACE SHEET and H&P or most recent chart note.
2. Hepatitis B (Hep B surface antigen and core antibody) screening must be completed prior to initiation of therapy and the patient should not be infected.
3. Patient should have regular monitoring for hepatitis B, infection, and renal dysfunction.

PRE-SCREENING: (Results must be available prior to initiation of therapy):
□ Hepatitis B Surface AG, serum, Routine, ONCE, prior to initiation of therapy if not already done
□ Hepatitis B Core AB Qual, serum, Routine, ONCE, prior to initiation of therapy if not already done
OR
□ Hepatitis B surface antigen and core antibody test results scanned with orders

LABS:
□ CBC with differential, Routine, ONCE, every _______ (visit)(days)(weeks)(months) – Circle One
□ Liver Set (AST, ALT, BILI TOTAL, BILI DIRECT, ALK PHOS, ALB, PROT TOTAL), Routine, ONCE, every _______ (visit)(days)(weeks)(months) – Circle One
□ Labs already drawn. Date: ________

NURSING ORDERS:
1. Please indicate result of Hepatitis B surface antigen and core antibody tests and date:
   Results positive (+) (date): __________________ Results negative (-) (date): __________________
2. **First infusion or prior infusion reactions**: infuse rituximab via pump (no additional filter is required) slowly at 50 mg/hr for the first hour. If no infusion related reactions are seen, increase rate gradually by 50 mg/hr every 30 minutes to a maximum of 400 mg/hr.
3. **Subsequent infusions if no infusion reactions**: infuse rituximab via pump at 100 mg/hr for the first hour. If no infusion related reactions are seen, increase rate gradually by 100 mg/hour every 30 minutes to a maximum of 400 mg/hour as tolerated.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes
### PRE-MEDICATIONS:
(Administer 30 minutes prior to infusion)

*Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)*

1. acetaminophen (TYLENOL) tablet, oral, ONCE, every visit
   - 650 mg
   - 325 mg
   - 500 mg
   - 1000 mg

2. diphenhydramINE (BENADRYL) capsule, oral, ONCE, every visit
   - 25 mg
   - 50 mg

3. loratadine (CLARITIN) tablet, oral, ONCE, every visit
   *(Choose as alternative to diphenhydramine if needed)*
   - 10 mg
   - 5 mg

4. methylPREDNISolone sodium succinate (SOLU-MEDROL), intravenous, ONCE, every visit
   - 125 mg
   - 40 mg

### MEDICATIONS:

- **riTUXimab-abbs (TRUXIMA)** 1000 mg in sodium chloride 0.9%, intravenous, ONCE, Infuse per nursing order

### Interval: *(must check one)*

- Once
- Every 2 weeks x 2 doses
- Every ____ weeks x ____ doses

### HYPERSENSITIVITY MEDICATIONS:

1. **NURSING COMMUNICATION** – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.

2. diphenhydramINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction

3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity or infusion reaction

4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

5. famotidine (PEPCID) 20 mg, intravenous, AS NEEDED x1 dose, for hypersensitivity or infusion reaction

6. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for infusion related fever

7. meperidine (DEMEROL) injection, 25-50 mg, intravenous, EVERY 2 HOURS AS NEEDED for infusion-related severe rigors in the absence of hypotension, not to exceed 50 mg/hr

8. sodium chloride 0.9% solution, 1000 mL, intravenous, AS NEEDED, Infuse at 200 mL/hr when infusion is stopped for emergency or PRN medications
By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in:  □ Oregon  □ ________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);

My physician license Number is # ________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ____________________________  Date/Time: ____________________________
Printed Name: ____________________________  Phone: ____________________________  Fax: ________________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

□ Beaverton
  OHSU Knight Cancer Institute
  15700 SW Greystone Court
  Beaverton, OR 97006
  Phone number: 971-262-9000
  Fax number: 503-346-8058

□ NW Portland
  Legacy Good Samaritan campus
  Medical Office Building 3, Suite 150
  1130 NW 22nd Ave.
  Portland, OR 97210
  Phone number: 971-262-9600
  Fax number: 503-346-8058

□ Gresham
  Legacy Mount Hood campus
  Medical Office Building 3, Suite 140
  24988 SE Stark
  Gresham, OR 97030
  Phone number: 971-262-9500
  Fax number: 503-346-8058

□ Tualatin
  Legacy Meridian Park campus
  Medical Office Building 2, Suite 140
  19260 SW 65th Ave.
  Tualatin, OR 97062
  Phone number: 971-262-9700
  Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders