



Oregon Health & Science University  
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER  
**riTUXimab-abbs (TRUXIMA) Infusion  
for Kidney Transplant Rejection**

Page 1 of 3

ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

Patient Identification

**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE.**

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\*\***

**\*\* Height, weight, and BSA are required for a complete order\*\***

**GUIDELINES FOR ORDERING**

1. Send **FACE SHEET and H&P or most recent chart note.**
2. Hepatiti Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. If patient is at high risk for TB exposure, a Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. 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 antigen and core antibody total test results scanned with orders.
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

**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. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
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



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**PRE-MEDICATIONS:** (Administer 30 minutes prior to infusion)

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
2. diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.  
**Give either loratadine or diphenhydrAMINE, not both.**
3. loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. **Give either loratadine or diphenhydrAMINE, not both.**
4. methylPREDNISolone sodium succinate (SOLU-MEDROL), 125 mg, intravenous, ONCE, every visit

**MEDICATIONS:**

(If insurance requires a different biosimilar agent, pharmacy will update the order per OHSU CDTM).

- riTUXimab-abbs (TRUXIMA) 375 mg/m<sup>2</sup> = \_\_\_\_\_ 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, HMC C-132). 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.



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**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](http://www.ohsuknight.com/infusionorders)