BARNES-JEWISH Hospital BJC HealthCare

Washington University in St. Louis SCHOOL OF MEDICINE

RITUXIMAB (RITUXAN) ORDERS

PATIENT IDENTIFICATION

UNLESS THE WORD SPECIFIC IS WRITTEN AFTER A DRUG ORDER BY TRADE NAME, A GENERIC EQUIVALENT DRUG APPROVED BY THE PHARMACY AND THERAPEUTICS COMMITTEE MAY BE DISPENSED IN ACCORDANCE WITH THE MEDICAL STAFF BYLAWS.

Please check (✔) the appropriate box(es) (☐) and fill in the blank(s) as needed.

ORDERS

Patient's Name: **DOB:**

THIS ORDER EXPIRES IN ONE YEAR.

Admit to: ☐ Outpatient: Minor Procedures Center ☐ Inpatient

Indicated for: ☐ Autoimmune myopathy Dx: _____
☐ Autoimmune neuropathy Dx: _____
☐ Neuromuscular Junction Disorder Dx: _____
☐ Rheumatoid Arthritis: _____
Other:

Monitoring: Vitals signs on initial evaluation and then Q15 minutes x4, Q30 minutes x4, and then Q1 hour.

Diet: ☐ Regular Other:

Activity: Up ad lib.

Nursing / Treatments: Obtain Height and Weight for Rituximab (Rituxan) dosing.
Ht: _____ Wt: _____ BSA: _____
Confirm Rituximab (Rituxan) dose as 375mg/meter^2 (Max BSA 2 meters^2) with physician prior to each infusion.
Initiate IV access
Discontinue IV access at discharge
If Outpatient: Discharge patient after infusion.

Labs:
☐ Immunocompetency Panel-label "Examine for CD19 & CD3"
☐ Serum Quantitative Immunoglobulin
☐ Serum Immunofixation
☐ CBC express, BMP (Electrolytes, Glucose and Creatinine)
Other:

Dr. Pestronk's Labs - send to IWJ-404:
☐ Anti Chimeric Antibodies
☐ 2 RED TOP Tubes

IV Fluids:
☐ 1000mL NS at 100mL/hour via peripheral IV line
☐ NS at KVO during infusion.
Other:

Medications:
Pre-Medications: Give 30 minutes prior to Rituximab infusion for infusion reaction prophylaxis.
Choose One: ☐ DiphenhydrAMINE (Benadryl) _____ mg IVP x1 dose.
☐ DiphenhydrAMINE (Benadryl) _____ PO x1 dose.
☐ Acetaminophen (Tylenol) 650mg PO x 1 dose.
☐ MethylPREDNISolone _____ mg IVP x1 dose
Other:

DATE	TIME	
		Physician: _____ (SIGNATURE REQUIRED) _____ (PRINTED NAME REQUIRED) Telephone #/Pager # _____

DO NOT WRITE BELOW THIS LINE

BJ 2-3343-615

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ORDERS

Neuromuscular Infusion/Procedure:

☐ **Rituximab dose: 375mg/m² (maximum BSA of 2 meter²)** _____ **mg total dose to be given.**

Rheumatoid Arthritis:

☐ **Rituximab dose: 1000mg in 500mL of normal saline**

BJH Infusion/Procedure:

☐ Initial infusion: Infuse at 50mg/hour.
Increase rate every 30 minutes by 50mg/hour as tolerated to a maximum of 400mg/hour.

☐ Subsequent infusions: Infuse at 100mg/hour.
Increase rate every 30 minutes by 100mg/hour to a maximum of 400mg/hour

Other: _____

☐ **For Reactions:** T greater than 38C
Cardiac or Respiratory symptoms
Rash

Stop infusion.

☐ Contact Dr. _____ at Pager # _____

☐ Contact Neurology resident at Pager # _____

☐ For any other issues, contact the Neurology Resident immediately.
(A neurology fellow is available 24 hours a day if needed at pager # 338-6138.)

☐ **Repeat orders every** **weeks x** **doses.**

DATE	TIME	
		Physician: _____ (SIGNATURE REQUIRED) _____ (PRINTED NAME REQUIRED) Telephone #/Pager #_____

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