

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/meter² (Max BSA 2 meters²) 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 # _____



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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: _____ <small>SIGNATURE REQUIRED</small>	Telephone #/Pager # _____ <small>PRINTED NAME REQUIRED</small>
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DO NOT WRITE BELOW THIS LINE

