Rituximab
(RITUXAN)

TOTAL INFUSION
human-centered care

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605
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Name: _____

DOB: _____ Phone: _____

Gender: ☐ Male ☐ Female

Allergies: _____

DIAGNOSIS (ICD-10 code required):

- ☐ _____ Rheumatoid Arthritis (RA)
- ☐ _____ Granulomatosis w/Polyangitis (GPA)
- ☐ _____ Microscopic Polyangitis (MPA)
- ☐ _____ Pemphigus Vulgaris (PV)
- ☐ _____ Other: _____

PROVIDER REMINDERS:

- All orders with a ☑ will be placed unless otherwise noted
- Screen for viral hepatitis prior to use
- CBC, ALT, AST, and Creatinine before treatment start day

TREATMENT CRITERIA:

Hold Rituximab (RITUXAN) if:

- Temperature **GREATER THAN** 100 degrees F
- Complains of symptoms of acute viral or bacterial illness
- Taking antibiotics for current infection
- *Initial dose only:* Unable to verify negative HBV results

Notify Provider if:

- New or worsening neurological symptoms such as memory loss, trouble thinking, dizziness, loss of balance, loss of vision, difficulty talking or walking

Nursing Considerations:

- Monitor for adverse reaction, including vital signs and pulse ox, every 30 minutes until max infusion rate achieved, then at the end of infusion

☑ **IV LINE CARE** per Nursing Policy

☑ **INFUSION REACTION MEDICATIONS** per Standardized Procedures

☑ **TREATMENT ORDER WEIGHT** will be utilized for the duration of the order. Patient will be weighed prior to every treatment. Prescriber will be notified of weight change greater than 10% from baseline weight.

Premedications

☑ **Acetaminophen (TYLENOL) 650mg PO**, Once, 30 minutes prior to Rituximab infusion.

☑ **Cetirizine (ZYRTEC) 10mg PO**, Once, 60 minutes prior to Rituximab infusion.

☑ **Methylprednisolone Sodium Succinate (SOLU-MEDROL) 125mg IVP**, Once, 30 minutes prior to Rituximab infusion.

Medications

Patient Weight _____kg **(REQUIRED)**

Infuse **Rituximab (RITUXAN)** Intravenously

Dose:

☐ 500mg ☐ 375mg/m^2
☐ 1,000mg ☐ _____

Initial Dose: Initiate infusion at a rate of 50 mg/HOUR. In the absence of adverse reaction , increase infusion rate by 50 mg/HOUR increments every 30 minutes, to a maximum rate of 400 mg/HOUR.

Subsequent Infusions: Initiate infusion at a rate of 100 mg/HOUR. In the absence of adverse reaction, increase infusion rate by 100 mg/HOUR increments every 30 minutes, to a maximum rate of 400 mg/HOUR.

Frequency:

☐ Two doses, two weeks apart [Initial dose (Day 1), followed by second dose on (Day 15)]
☐ Four doses [once weekly for 4 weeks]
☐ Single dose

☑ **Meperidine (DEMEROL) 25mg IVP**, Once PRN, for shaking, chills, or rigors. May repeat x1 in 15 minutes if symptoms unresolved.

☐ **Methylprednisolone Sodium Succinate (SOLU-MEDROL) 1000mg IV (NOT ROUTINE; RECOMMENDED TO TREAT SEVERE VASCULITIS SYMPTOMS)** Once Daily, Days 1-3.

Special Instruction(s):

Provider Signature _____ Date _____ Email _____

Printed Name _____ Phone _____ Fax _____

Office Contact _____ Phone _____ Email _____