



Rituximab-abbs (TRUXIMA)

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)
- _____ 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-abbs (TRUXIMA) 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-abbs infusion.
- Cetirizine (ZYRTEC) 10mg PO**, Once, 60 minutes prior to Rituximab-abbs infusion.
- Methylprednisolone Sodium Succinate (SOLU-MEDROL) 125mg IVP**, Once, 30 minutes prior to Rituximab-abbs infusion.

Medications

Patient Weight _____kg (**REQUIRED**)

Infuse **Rituximab-abbs (TRUXIMA)** Intravenously

Dose:

- 500mg 375mg/m²
- 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 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 _____