Columbus Community Hospital
Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS
(including Medications)

riTUXimab Infusion **(8/2024)**

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

GUIDELINES FOR ORDERING

1. Send **FACE SHEET** and **H&P or most recent chart note.**
2. 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 if patient is at high risk for TB exposure.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.
- ☐ TB screening is not necessary. Patient is not at high risk for TB exposure.

LABS:

- ☐ CBC with differential, Routine, ONCE, every_____ (visit)(days)(weeks)(months) – Circle One
- ☐ Other_____

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:** 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. NURSING COMMUNICATION-- Monitor patient for riTUXimab infusion related reactions for 1 hour (first infusion) or 30 minutes (second infusion) after completion of riTUXimab infusion. Monitoring not required for third infusion and beyond, if no previous infusion reactions. Lengthened monitoring recommended for previous infusion reactions, contact provider for guidance.
5. VITAL SIGNS -- First infusion: During riTUXimab infusion obtain vital signs at baseline, then every 15 minutes for the first hour, then every 30 minutes with rate escalation, then every hour for the duration of the infusion.
6. VITAL SIGNS -- Subsequent infusions: During riTUXimab infusion obtain vital signs at baseline, then every 30 minutes with rate escalation, then every hour for the duration of the infusion.
7. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

(cont.)

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riTUXimab Infusion

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
- ☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE every visit.
- ☐ methylPREDNISolone sodium succinate (SOLU-MEDROL), 125 mg, intravenous, ONCE, every visit
- ☐ Other: _____

MEDICATIONS:
- riTUXimab 1000 mg in sodium chloride 0.9%, intravenous, ONCE, Infuse per nursing order.

Product selection (must check one)
- ☐ TRUXIMA (riTUXimab-abbs) (CCH preferred brand)
- ☐ RUXIENCE (riTUXimab-pvvr)
- ☐ RIABNI (riTUXimab-arrx)
- ☐ RITUXAN (riTUXimab)
- ☐ _____

At CCH, if insurance requires a different biosimilar agent, pharmacy will update the order.
- ☐ **Only check this box if it is NOT okay to substitute for insurance. Dispense as written (DAW)**

Interval: (must check one)
- ☐ Once
- ☐ Initial Dosing: Every 2 weeks x 2 doses
- ☐ Maintenance Dosing: Once every 26 weeks (6 months) after treatment initiation
- ☐ Every _____ weeks x _____ doses

HYPERSENSITIVITY:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION**.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:
- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

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My NPI 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.

Provider signature: _____ Date/Time: _____

Printed Name: _____ Phone: _____Fax: _____