Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265

STANDARD RITUXIMAB PLAN OF TREATMENT

(Re)Certification Period From_____to_____

NOTE: Patient is *ineligible* to receive Rituximab if receiving antibiotic for active infectious process due to the possibility of developing a superinfection related to its effect on the immune status, or has a suspected infectious process.

Patients Name _____Ht_____Wt _____Allergies:_____

DIAGNOSIS: . ☐ 714.0 or ☐ 714.2 Rheumatoid Arthritis

Physician Office to Complete:

1. **Has your patient had failure, intolerance, or contraindication to conventional therapy?**
   □ Yes □ No
2. **If yes, please specify, treatment/medication tried and outcomes:_____**

_____

PREMEDICATE:

Thirty minutes prior to infusion with Acetaminophen 650mg PO, Diphenhydramine 25mg IVP & Methylprednisolone 125mg IVP.

Or ☐ Other_____

Obtain weight each visit.
Vital signs: baseline, every 15 minutes for one hour beginning at start of infusion, then every 30 minutes until infusion is complete, and 30 minutes after completion for the first 2 treatments. After first round of Rituxan VS: baseline, every 30 mins until complete then 30 after completion. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy. Pump, tubings, and supplies needed to complete prescribed therapy.

If adverse drug reaction, implement the Standard Adverse Reaction Protocol.

Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.
Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 0.9% or D5W 20-50 ml to flush tubing/line followed by Heparin Lock 1 – 5 ml 100 unit/ml as needed per line type.

DOSE:

_____ **Rituximab 1000mg IV** per 500ml normal saline to infuse per protocol ***OR***
_____ Other: _____

FREQUENCY:

_____ Orders to be completed at ___0, ___2 weeks and _____ every 4 months or _____ every 6 months

_____ Special Orders:_____

OTHER:

Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures, Please)

Physician's Signature: _____/ _____Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name:_____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION to

866-872-8920