Memorial Healthcare System

RITUXIMAB & BIOSIMILARS

PATIENT INFORMATION / REFERRAL STATUS

Referral Status: □ New Referral □ Updated Order □ Order Renewal **Date:** _____

Patient Name: _____ DOB: _____

ICD-10 Code: _____ ICD-10 Description/Diagnosis: _____

Allergies: □ NKDA Allergies: _____ Weight: _____ □ lbs/□ kg Height: _____

Patient Status: □ New to Therapy □ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER / PRACTICE INFORMATION

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Referral Coordinator Name: _____ Email: _____ Alternative Phone Number: _____

REFERRING PROVIDER COMMUNICATIONS

□ I have reviewed the prescribing information and medication guide for Rituxan/Riabni/Ruxience/Truxima (rituximab/rituximab-arrx,-pvvr,-abbs).

- This therapy plan is intended for diagnosis of Rheumatoid Arthritis, Multiple sclerosis, Myasthenia gravis, Neuromyelitis optica, IgG4-related disease, lupus nephritis and other non-oncology indications.
- Avoid use of live vaccines during treatment. Prior to initiating therapy, complete all age-appropriate vaccinations according to current immunization guidelines.
- Evaluate for active infection. Delay administration to patients with an active infection.
- Evaluate patients for viral hepatitis and treat them according to guidelines prior to initiating therapy. Consider periodic evaluation of patients who are hepatitis B carriers for signs/symptoms of active hepatitis B infection.
- Progressive multifocal leukoencephalopathy (PML) may occur, consider the diagnosis in any patient with new-onset neurologic manifestations.
- Prophylaxis against opportunistic infection and/or viral reactivation may be warranted during and up to 12 months after completion of rituximab therapy.

NURSING PROTOCOL COMMUNICATIONS

☒ Provide nursing care, vital signs, monitoring according to Memorial Outpatient Procedures. Establish/maintain IV access and administer medication as ordered. Remove peripheral IV access after infusion completion if applicable. Follow infusion-related/hypersensitivity reactions management according to MHS Outpatient Adverse Reaction Protocol available for review on at mhs.net/services/pharmacy/infusion-services/outpatient-infusion.

☒ Discharge/Follow-up instructions according to Memorial Outpatient Procedures.

LABORATORY ORDERS

□ **Pregnancy, Urine for females of childbearing potential who have not undergone a hysterectomy:** At least 1 week prior to infusion

□ ***CBC with Diff:*** At least 1 week prior to infusion

□ ***Comprehensive Metabolic Panel:*** At least 1 week prior to infusion

□ ***CRP:*** □ Once □ Every Visit □ Every ____ months

□ ***Hep B surface antigen:*** □ Once □ Every Visit □ Every ____ months

□ ***Hep B surf. antibody quantitative:*** □ Once □ Every Visit □ Every ____ months

□ ***Hep B core antibody, total [anti-HBc]:*** □ Once □ Every Visit □ Every ____ months

PRE-MEDICATION ORDERS (30-60 Minutes Prior to Therapy)

☐ Acetaminophen (Tylenol) 650 mg PO

☐ Diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV **OR**

☐ Cetirizine (Zyrtec) or Loratadine (Claritin) 10 mg PO

☐ Methylprednisolone (Solu-Medrol) ☐ 40 mg ☐ 125 mg IV **OR**

☐ Dexamethasone (Decadron) ☐ 8 mg ☐ 20 mg PO

☐ Other: _____ Dose: _____ Route: _____ Frequency/Timing: _____

THERAPY PLAN

Select Product:

☐ MHS Pharmacy to select product based on payor requirements, product availability, and indication.

OR Do Not Substitute and use product below (Check One):

☐ Rituximab (Rituxan) ☐ Rituximab-arrx (Riabni) ☐ Rituximab-pvvr (Ruxience) ☐ Rituximab-abbs (Truxima)

Route: ☒ IV ☐ SQ ☐ IM

Dose: ☐ 1000 mg/NS 500 mL ☐ 500 mg/NS 250 mL ☐ 375mg/m ^{2} ☐ Other (**indicate units**): _____

Initial Frequency:

☐ Once weekly x 4 doses ☐ Every 2 weeks x 2 doses ☐ Other: _____

Maintenance Frequency:

☐ Every _____ weeks ☐ Other: _____

Diluent/Volume/Concentration/Special tubing/Filters will be in accordance with the product package insert.

☒ Flush with 0.9% sodium chloride at completion per protocol or medication-specific instructions

Additional Administration Instructions:

Do not infuse with other agents. Pre-medicate prior to each infusion. Start infusion at a rate of 50 mg/h, if there is no reaction, increase rate by 50 mg/hr every 30 minutes, to a maximum of 400 mg/hr. If an infusion-related reaction occurs, slow or stop the infusion. After reaction has been resolved, restart infusion at 50% of the previous rate. Discontinue infusion in the event of serious or life-threatening cardiac arrhythmia.

Note to Pharmacy/Comments:

Concentration should range between 1 mg/mL and 4 mg/mL._____

_____

Refills: ☐ Zero ☐ for 12 months ☐ Other:_____

(if not indicated, order will expire one year from date signed)

_____	_____	_____
Provider Name (Print)	***Provider Signature***	***Date***

Memorial Healthcare System

Adverse Reaction Management Protocol (Adult)

Observe patient for infusion related and hypersensitivity reactions such as fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting.

If reaction occurs:

- Stop infusion and assess patient.
- Maintain or establish vascular access if needed
- **Administer emergency medication(s) according to symptoms:**

☒ Acetaminophen 650 mg PO once PRN headache, pain, fever >100.4F, chills or rigors.

☒ Diphenhydramine 50 mg IV once PRN itching, allergies, infusion reaction, hives, pruritic and other nonspecific symptoms of allergic reaction **OR**

☒ Diphenhydramine 50 mg IM once PRN itching, allergies, infusion reaction, hives, pruritic and other nonspecific symptoms of allergic reaction (if no IV access)

☒ Dexamethasone 10 mg IV once PRN shortness of breath or wheezing **OR**

☒ Dexamethasone 10 mg IM once PRN shortness of breath or wheezing (if no IV access)

☒ Ondansetron 4 mg IV once PRN nausea, vomiting **OR**

☒ Ondansetron 4 mg IM once PRN nausea, vomiting (if no IV access)

- May re-start therapy if appropriate when symptoms resolve. Resume infusion at 50% of the previous rate and increase per manufacturer's guidelines.

If a severe allergic/anaphylactic reaction occurs

- Symptoms are rapidly progressing or continuing after administration of PRN medications and/or signs and symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension)

☒ Notify the Rapid Response / Rescue Alert Team / Blue Alert / 911.

☒ Initiate BLS/ Cardiopulmonary resuscitation if necessary.

☒ Administer Epinephrine 0.3 mg intramuscularly, every 5 MIN PRN rapidly progressing or continuing after administration of PRN medication or signs and symptoms of severe allergic/anaphylactic reaction. Administer every 5-15 minutes as needed preferably in the outer thigh.

☒ Place the patient in a recumbent position, elevate lower extremities.

☒ Continuously monitor vital signs (blood pressure, pulse oximetry, and heart rate).

☒ Contact and notify the referring provider on the day of occurrence once patient is stabilized.

☒ Document reaction in the medical record and complete an incident report once patient is stabilized.