NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-515-5089
Phone: 405-515-2470

ORD

Rituximab (Rituxan)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment: _____

☐ Rheumatoid Arthritis, unspecified (M06.9)

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port

☑ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

Other: _____

Premedication

☐ DiphenhydrAMINE (Benadryl) 25 MG ORAL ONCE
☐ DiphenhydrAMINE (Benadryl) 50 MG IV PUSH ONCE (J1200 : 50 MG = 1 unit)
☐ Acetaminophen (Tylenol) 325MG 2 TAB ORAL ONCE
☐ methylPREDNISolone (Solu-Medrol) 125 MG IV PUSH ONCE – 30 minutes prior to infusion (J2930 : 125 MG = 1 unit)

Infusion – Rituximab (Rituxan) [J9312 : 10 MG = 1 unit]

☐ RITUximab (Rituxan) _____ milligram/meter squared INTRAVENOUS over 3 to 8 hours. **First dose** – start at 50 MG/HR for 1 hour, then increase rate by 50 MG/HR EVERY 30 MINUTES. **Subsequent doses** – start at 100 MG/HR and increase by 100 MG/HR. DO NOT EXCEED MAX rate of 400 MG/HR.

Rheumatoid Arthritis

☐ RITUximab (Rituxan) 1000 MG in 500 mL of 0.9% Normal Saline Solution (EXACT AMOUNT) INTRAVENOUS over 3 to 8 hours. **First dose** – start at 50 MG/HR for 1 hour, then increase rate by 50 MG/HR EVERY 30 MINUTES. **Subsequent doses** – start at 100 MG/HR and increase by 100 MG/HR. Administer on day 1 and day 15. DO NOT EXCEED MAX rate of 400 MG/HR

Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

08142512

DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES