



Patient Name: _____

Date of Birth: _____

PHYO
CMC85048-001NS Rev. 3/2021

Rituximab (RITUXAN) (Neurology) Infusion Therapy Plan

Baseline Patient Demographic

To be completed by the ordering provider.

Diagnosis: _____ Height: _____ cm Weight: _____ kg Body Surface Area: _____ (m²)
 NKDA - No Known Drug Allergies Allergies: _____

Therapy Plan orders extend over time (several visits) including recurring treatment.

Please specify the following regarding the entire course of therapy:

Duration of treatment: _____ weeks _____ months _____ unknown

Treatment should begin: as soon as possible (within a week) within the month****Plans must be reviewed / re-ordered at least annually. ****

ORDERS TO BE COMPLETED FOR EACH THERAPY

ADMIT ORDERS

 Height and weight Vital signs

Hypotension Defined Admit

 Nursing communication

Prior to starting infusion, please determine the patient's threshold for hypotension as defined by the following parameters. This information will be needed in the event of an infusion reaction occurring.

Hypotension is defined as follows:

1 month to 1 year - systolic blood pressure (SBP) less than 70

1 year to 11 years - systolic blood pressure (SBP) less than 70 + (2 x age in years)

11 years to 17 years - systolic blood pressure (SBP) less than 90

OR any age - systolic blood pressure (SBP) drop of more than 30% from baseline.

Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.

PREGNANCY TESTS AT DALLAS AND PLANO

Nursing communication

Only one pregnancy test is necessary, based on facility capabilities. Please utilize the lab that is available per facility.

 Patient requires a pregnancy test (based on organizational policy, female patients over 10 require a pregnancy test)

Pregnancy test, urine - POC

STAT, ONE TIME, for females > 10 years old. If positive, do NOT infuse and contact the ordering provider.

Gonadotropin chorionic (HCG) urine

STAT, ONE TIME, unit collect, for females > 10 years old. If positive, do NOT infuse and contact ordering provider.

NURSING ORDERS

 Nursing communication

Confirm TB test is negative within last year, if no test or positive, contact ordering provider.

IV START NURSING ORDERS

 Insert peripheral IV / Access IVAD

Place PIV if needed or access IVAD if available



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ORDERS TO BE COMPLETED FOR EACH THERAPY

NURSING ORDERS, CONTINUED

Please select all appropriate therapy

lidocaine 1% BUFFERED (J-TIP LIDOCAINE)

0.2 mL, INTRADERMAL, PRN

when immediate procedure needed when procedure will take about 1 minute patient / family preference for procedure

Administration Instructions: NOTE: Do not use this medication in patients with bleeding disorders, platelets \leq 20,000, or in patients taking anticoagulants, when accessing implanted ports or using a vein that will be utilized for chemotherapy administration, nor for pre-term infants or neonates.

lidocaine - prilocaine (EMLA) cream

TOPICAL, PRN

when more than 60 minutes are available before procedure when procedure will take more than 1 hour

patient / family preference for procedure

Administration Instructions: NOTE: In children < 3 months of age, or < 5 kg in weight, maximum application time is 1 hour.

lidocaine - tetracaine (SYNERA) patch

TOPICAL, PRN

when 20 - 30 minutes are available before procedure when procedure will take more than 1 hour

when anticipated pain is less than 5 mm from skin surface patient / family preference for procedure

lidocaine with transparent dressing 4% kit

TOPICAL, PRN

when 20 - 30 minutes are available before procedure when procedure will take more than 1 hour

patient / family preference for procedure

Heparin flush

heparin flush

10 - 50 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. This heparin flush should be used with all central lines including IVADs, with the exception of de-accessing the IVAD.

heparin flush

100 - 300 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. For use only when de-accessing IVADs.

Sodium chloride flush

Sodium chloride flush 0.9% injection

1 - 20 mL, INTRAVENOUS, PRN, IV line flush

Sodium chloride - preservative free 0.9% injection

1 - 30 mL, INTRAVENOUS, PRN, IV line flush

LABS - SEMI ANNUAL

Nursing communication

If hepatitis B and C labs and quantiferon TB gold have been obtained in the last 90 days, defer drawing until the next infusion.

HEPATITIS B LABS

Hepatitis B Core Antibody Total

Unit collect

INTERVAL: Every 26 weeks

DEFER UNTIL: _____

Key: cm = centimeter; gm = gram; HCG = human chorionic gonadotropin; IV = intravenous; IVAD = implantable venous access device; kg = kilogram; m² = square meters; mg = milligram; mg/m² = milligram per square meter; mL = milliliter; mL / hr = milliliters per hour; mm = millimeter; mmHg = millimeters of mercury; mOsm / L = milliosmole per liter; NKDA = No Known Drug Allergies; NS = normal saline; pH = hydrogen ion concentration; PIV = peripheral intravenous; POC = point of care; PRN = as needed; RTA = ready to administer; SBP = systolic blood pressure; STAT = immediately



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LABS - SEMI ANNUAL

- | | | |
|---|---------------------------------|---------------------------|
| <input checked="" type="checkbox"/> Hepatitis B Surface Antigen
Unit collect | INTERVAL: Every 26 weeks | DEFER UNTIL: _____ |
| <input checked="" type="checkbox"/> Hepatitis B Surface Antibody
Unit collect | INTERVAL: Every 26 weeks | DEFER UNTIL: _____ |
| <input checked="" type="checkbox"/> Hepatitis C Antibody
Unit collect | INTERVAL: Every 26 weeks | DEFER UNTIL: _____ |
| <input checked="" type="checkbox"/> Quaniferon TB Gold
Unit collect | INTERVAL: Every 26 weeks | DEFER UNTIL: _____ |

PRE-MEDICATIONS

- Acetaminophen pre-medication 30 minutes prior (15 mg / kg, maximum 650 mg)**
Nursing communication
 Administer only one of the acetaminophen orders, suspension or tablets, do not give both.
acetaminophen suspension
 15 mg / kg, ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____
acetaminophen tablet
 15 mg / kg ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____
- Diphenhydramine pre-medication 30 minutes prior (1 mg / kg, maximum 50 mg)**
Nursing communication
 Administer only one of the diphenhydrAMINE pre-medication orders, liquid, capsule or injection, do not give more than one of the orders as a pre-medication.
diphenhydrAMINE liquid
 1 mg / kg, ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____
diphenhydrAMINE capsule
 1 mg / kg ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____
diphenhydrAMINE injection
 1 mg / kg, INTRAVENOUS, 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____
- methylPREDNISolone RTA infusion**
 2 mg / kg INTRAVENOUS, for 1 dose. Give 30 minutes prior to riTUXimAB Ready to administer by IV infusion. Doses > 15 mg / kg should be given over a minimum of 1 hour. (see protocol for monitoring parameters.)
Dose: _____
- cetirizine tablet 10 mg**
 10 mg, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

INTRA-PROCEDURE

- Nursing communication**
 Adverse reactions may include fever, chills, rigors, hypotension and severe allergic reactions (anaphylaxis)

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INTRA-PROCEDURE, CONTINUED

Vital signs

Obtain baseline vitals prior to start of riTUXimab infusion. Then monitor vitals 15 minutes after initiation of the infusion and 15 minutes after each rate change. Check vitals at the completion of the infusion and observe post infusion based on patient status.

Physician communication order

Routine, until specified, starting when released, Please round riTUXimab dose, if clinically acceptable, to nearest 100 mg to minimize waste. Dose riTUXimab: 1,000 mg every 6 months or 375 mg / m² every 6 months. Please enter the dose of riTUXimab in 'mg' to facilitate prior authorization requirements.

riTUXimab 1,000 mg in sodium chloride 0.9% 900 mL infusion **INTERVAL: Every visit** **DEFER UNTIL:** _____

Dose: _____

Initial infusion	first hour infusion rate	0.5 mg / kg / hr	maximum rate: 50 mg / hr
	if no infusion related events observed after 60 minutes	Increase rate by 1 mg / kg / hr	maximum rate: 100 mg / hr
	if no infusion related events observed after 30 minutes	Increase rate by 0.5 mg / kg / hr	maximum rate: 400 mg / hr
Subsequent infusion	first hour infusion rate	1 mg / kg / hr	maximum rate: 100 mg / hr
	if no infusion related events are observed after 30 minutes	Increase rate by 1 mg / kg / hr	maximum rate: 400 mg / hr

Therapy Appointment Request

Please select department for the therapy appointment request:

Expires in 365 days

- Dallas Special Procedures Plano Infusion Center Dallas Allergy Dallas Transplant Dallas Neurology

EMERGENCY MEDICATIONS

Nursing communication

1. Hives or cutaneous reaction only – no other system involvement

PATIENT IS HAVING A DRUG REACTION:

- a. Stop the infusion
- b. Give diphenhydramine as ordered
- c. Check heart rate, respiratory rate and blood pressure every 5 minutes until further orders from provider.
- d. Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation) if not already on one
- e. Notify provider for further orders

2. Hives or cutaneous reaction plus one other system, i.e. abdominal cramping, vomiting, hypotension, altered mental status, respiratory distress, mouth / tongue swelling

PATIENT IS HAVING ANAPHYLAXIS:

- a. Stop the infusion
- b. Call code – do not wait to give epinephrine
- c. Give epinephrine as ordered
- d. Notify provider
- e. Check heart rate, respiratory rate and blood pressure every 5 minutes until the code team arrives.
- f. Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation), if not already on one.
- g. Give diphenhydramine once as needed for hives
- h. May repeat epinephrine every 5 minutes x 2 doses for persistent hypotension and respiratory distress with desaturation until code team arrives.
- i. May give albuterol as ordered for wheezing with oxygen saturation stable while waiting for code team, continue to monitor oxygen saturation.

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EMERGENCY MEDICATIONS, CONTINUED

Hypotension is Defined as Follows:

- 1 month to 1 year – systolic blood pressure (SBP) less than 70
- 1 year to 11 years – systolic blood pressure (SBP) less than 70 + (2 x age in years)
- 11 years to 17 years – systolic blood pressure (SBP) less than 90
- OR any age – systolic blood pressure (SBP) drop more than 30% from baseline.
- Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.

**EPINEPHrine Injection Orderable For Therapy Plan
(AMPULE / EPI - PEN JR. / EPI - PEN) 0.01 mg / kg**

0.01 mg / kg, INTRAMUSCULAR, EVERY 5 MINUTES PRN, for anaphylaxis and may be repeated for persistent hypotension and respiratory distress with desaturation until the code team arrives, for 3 doses
Use caution with PIV administration. This solution has a pH < 5, or a pH > 9, or an osmolality > 600 mOsm / L.

Dose: _____

**Cardio / Respiratory Monitoring
Rationale for Monitoring: High risk patient (please specify risk)**

- Clinically significant cardiac anomalies or dysrhythmias
- Recent acute life-threatening event
- Unexplained or acutely abnormal vital signs
- Artificial airway (stent, tracheostomy, oral airway)
- Acute, fluctuating or consistent oxygen requirements

Monitor Parameters (select all that apply): Heart rate Oxygen saturation Respiratory rate
Telemetry Required: Yes No

diphenhydrAMINE injection

1 mg / kg, INTRAVENOUS, ONCE PRN, for hives or cutaneous reaction, for 1 dose maximum dose = 50 mg per dose, 300 mg per day.

Dose: _____

Albuterol for aerosol

0.25 mg / kg., INHALATION ONCE PRN, for wheezing, but oxygen saturations stable while waiting for code team, continue to monitor oxygen saturation for 1 dose

Dose: _____

POST - PROCEDURE

Nursing communication

Flush PIV or IVAD with 20 mL 0.9% sodium chloride (250 mL bag) at the completion of the infusion.
Flush IVAD with saline and heparin flush per protocol prior to de-accessing IVAD.
Discontinue PIV prior to discharge.

Sodium chloride 0.9% infusion

INTRAVENOUS at 0 - 25 mL / hour, ONCE, for 1 dose.

Dose: _____

Signature of Provider (circle one):
MD DO _____ _____
Credentials Date Time

Printed Name of Provider

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