MIC **METRO INFUSION CENTER**

Name: _____
DOB _____
Diagnosis/Code: _____/_____
Cancer Stage: _____

Rituximab (Rituxan)-Biosimilars that can be used:

☐ Ruxience® (rituximab-pwr) ☐ Truxima® (rituximab-abbs) ☐ Riabni™ (rtixumab-arrx)

Please check the box corresponding to the weight used for dose calculation.

Height:_____in Weight: _____lbs ☐ Height has been measured not stated

☐ Call for weight change greater than 10% from baseline from weight listed on this order
☐ No dose modifications required for any weight change

BSA:_____m^2
☐ DuBois
☐ Mosteller

Patient Clearance:
Patient will be seen prior to every ___ cycle and cleared by oncology provider.
Laboratory or Other tests related to treatment that should be completed prior to clearance for infusion:
☐ Will be done at referring office (name and phone number of who to expect labs from):

Dosing Guidelines/Parameters: ***Provider must select hold parameters that will trigger a call from the Infusions staff***
☐ Treat with ANC greater than or equal to 1.5 or 1500; Platelets greater than or equal to 100,000
☐ Treat with ANC greater than or equal to_____; Platelets greater than or equal to_____

Hydration Orders: ☐ Not Required

Premedication and Antimetic Orders: ☐ No antiemetic needed *Minimal emetogenic potential*

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Acetaminophen (Tylenol)	☐ 650mg ☐ 1000mg	PO	----_____	30 minutes pre treatment
☐ Diphenhydramine (Benadryl)	☐ 25 mg ☐ 50mg	☐ PO ☐ IVP	_____	30 minutes pre treatment

Treatment Orders:

DRUG	DOSE CALCULATION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	DAYS TO BE GIVEN
☐ 1st Dose Rituximab (Rituxan)	☐ 375 mg/m^2 ☐ 500mg/ m^2	_____mg	As per pharmacy	IVPB	Initiate at 50mg/hr x 30 min Increase rate by 50mg q30 min to a max rate of 400mg/hr Infuse the remainder at 400mg/hr	☐ 1st dose only ☐ Every __ weeks if patient had a reaction with first dose
☐ 2nd dose and beyond Rituximab (Rituxan)	☐ 375 mg/m^2 ☐ 500mg/ m^2	_____mg	As per pharmacy	IVPB	Initiate at 100mg/hr x 30 min Increase rate by 100mg q30 min to a max rate of 400mg/hr Infuse the remainder at 400mg/hr	☐ Weekly x 4 ☐ Every 28 days ☐ Every 2 months ☐ Every 3 weeks ☐ _____
☐ 2nd dose and beyond Rituximab (Rituxan)	☐ 375 mg/m^2 ☐ 500mg/ m^2	_____mg	As per pharmacy	IVPB	Rapid Rituxan Infuse 20% of dose over 30 minutes with rest infusing over 1 hour	☐ Weekly x 4 ☐ Every 28 days ☐ Every 2 months ☐ Every 3 weeks _____

Date of intended first treatment at Metro Infusion Center: /subsequent treatments may be given +/- 2 days or as otherwise specified:
This order is good for 1 year from the date ordered

Call referring provider for:

DATE	Referring Provider:_____ _____Telephone#_____
	SIGNATURE REQUIRED PRINTED NAME REQUIRED

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627.
Send completed form and all documentation to confidential email: Intake@metroinfusioncenter.com or fax to (866)507-1164

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