MIC | METRO INFUSION CENTER

Rituximab (Rituxan)-Biosimilars that can be used: ☐ Ruxience® (rituximab-pwr) ☐ Truxima® (rituximab-abbs) ☐ Riabni™ (rtixumab-arrx)

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

Weight: _____lb_____kg **☐Height has been measured not stated**

☐ Call for weight change greater than 10% from weight listed on order

☐ No dose modifications required for any weight change

BSA:

☐ DuBois

☐ Mosteller

Patient Clearance: **Attach treatment Consent Form ☐**

Patient will be seen by Oncology Provider prior to every _____ cycle and cleared for treatment (Metro staff will also review symptoms prior to each treatment)

Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/_____days

Laboratory or Other tests related to treatment that should be completed by referring office prior to clearance for Infusion:

Will be done at referring office (Name and phone# of who to expect labs from):

☐ CMP with each treatment ☐ CBC with each treatment

☐ Other: _____-

Dosing Guidelines/Parameters: ***Provider must select parameters that will trigger a call from the Infusion staff***

☐ Hold and call provider for ANC: _____/Platelet:_____

☐ Other hold parameters based on drug _____

☐ No hold parameters

Hydration Orders: ☐ Not required ☐ Other_____

Premedication and Antiemetic orders:

Not required (list emetogenic potential)

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

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐1st Dose Rituximab (Rituxan)/ Biosimilar	☐ 375 mg/m2 ☐ 500mg/ m2	_____mg	As Per Pharmacy	IVPB	Initiate at 50mg/hr x 30 min Increase rate by 50mg q30min to a max rate of 400mg/hr Infuse the remainder at 400mg/hr	☐ 1st dose only _____
☐ 2nd dose and beyond Rituximab (Rituxan)/Biosimilar	☐ 375 mg/m2 ☐ 500mg/ m2	_____mg	As Per Pharmacy	IVPB	Initiate at 100mg/hr x 30min Increase rate by 100mg q30 min to a max rate of 400mg/hr Infuse the remainder at 400mg/hr**	_____ Frequency:_____
☐ 2nd dose and beyond Rituximab/Biosimilar	☐ 375 mg/m2 ☐ 500mg/ m2		As Per Pharmacy	IVPB	Rapid Rituxan Infuse 20% of dose over 30 minutes with rest infusing over 1 hour**	Frequency:_____

**To change to faster rates, the patient must not have had a reaction to the previous dose

Date of intended first treatment at Metro Infusion Center:_____Subsequent treatment 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: _____ _____ Phone# _____

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: MICreferral@metroinfusioncenter.com or fax to (866)507-1164.

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