MIC | METRO INFUSION CENTER

Name: _____
DOB_____
Diagnosis/Code: _____/_____

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: _____cm Weight: _____kg

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

BSA: _____ m^2

☐ DuBois

☐ Mosteller

Laboratory or Other Tests Related to Chemotherapy:

☐ CBC prior to treatment
☐ CBC PRN

Dosing Guidelines/ Parameters: **Provider must select one option below**

☐ Treat with ANC greater than or equal to 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 Antiemetic 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	Mix as a 1:1 mixture	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
☐ 2nd dose and beyond Rituximab (Rituxan)	☐ 375 mg/m^2 ☐ 500mg/ m^2	_____mg	Mix as a 1:1 mixture	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	Mix as a 1:1 mixture	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 first treatment: _____/subsequent treatments may be given +/- 5 days for greater than weekly
This order is good for 1 year from the date ordered

Call referring provider for:

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

Send a referral via fax at 866-507-1164 or email to the bionurses@metroinfusioncenter.com