

RiTUXimab
Infusion Therapy Plan Orders

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Name: _____
Kaiser Permanente Member I.D. #: _____
Date of Birth: _____

Instructions to Provider

Review orders and note any changes. All orders with will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers at the end of this protocol). Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all the following:

 Pre-Service Authorization has been obtained by Kaiser Permanente Fax: 1-888-282-2685 Voice: 1-800-289-1363

Order Date: _____	Diagnosis ICD-10 code (REQUIRED): _____
Weight: _____ kg	ICD-10 description: _____

General Plan Communication

- Biosimilar rITUXimab-arrr (Riabni) is the preferred and defaulted agent in this plan.
- **Dosing regimens:**
 - **Standard Dosing:** Administered as 2 doses of 500 – 1000 mg, two weeks apart (Day 1 and Day 15).
 - **Weekly Dosing:** Administered as 375 mg/m² once weekly for 4 weeks.
 - **Multiple Sclerosis Dosing:**
 - Administered as a dose of 1,000 mg x 1, then 500 mg every 6 months thereafter.
 - Some patients may start with a 500 mg dose x 1, then 500 mg every 6 months thereafter.
 - In addition, some patients may extend the dosing frequency (e.g., every 9 – 24 months), depending upon clinical factors.
- **Warning for hypogammaglobulinemia:**
 - RiTUXimab treatment can result in profound hypogammaglobulinemia along with increased infections in a subset of patients.
 - Please obtain baseline immunoglobulins (IgG, IgM, AND IgA) prior to initiation of treatment, before each cycle, and every 6 months x 2 after completion of treatment.
 - Please refer to/consult Allergy/Immunology if 1) levels are below normal prior to starting therapy or 2) levels are low and having frequent infections during therapy or 3) levels remain low beyond 9 months post treatment or if 4) IgG is less than 200 mg/dL at any point.
- **Special instructions/notes:**

Provider Information
Baseline Monitoring Parameters

- **Timing:** Within 3 months prior to expected therapy initiation
 - CBC with differential
 - Hepatitis B Core Antibody (Total)
 - Hepatitis B Surface Antigen and Hepatitis B Surface Antibody
 - Hepatitis C Screen
 - HIV Screen
 - Immunoglobulins (IgG, IgM, IgA)
 - Quantiferon – TB Gold
 - Varicella Immunity Screen (if no positive immunity screening available)
 - Not required for patients with documentation of appropriately timed vaccinations against varicella virus
 - Additional lab orders (for baseline): _____

Monitoring Parameters for Subsequent Infusions

- **Timing:** Within 2 months prior to infusion day (if subsequent infusions are scheduled more than 4 weeks apart)
 - CBC with differential

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- Immunoglobulins (IgG, IgM, IgA)
 Lymphocyte Subset
 Additional lab orders (for subsequent infusions): _____

Infusion Therapy
 Standard Dosing (Non-MS Indications)
riTUXimab-arrx in 0.9% sodium chloride IV infusion

[select one] **Dose:** 500 mg 1,000 mg

Route: Intravenous

Frequency: Once on Day 1 and 15

Infusion Rate (first dose):

- 50 - 400 mg/hr, titrated
- Initiate infusion rate at 50 mg/hr
- Slowly increase in increments of 50 mg/hr every 30 min to max of 400 mg/hr if no reaction

Infusion Rate (second dose):

- 125 - 400 mg/hr, titrated
- Initiate infusion rate at 125 mg/hr
- For subsequent infusions (if no previous infusion reaction): START at 125 mg/hr for 30 min, then 300 mg/hr for 30 minutes, then 400 mg/hr (MAX) until infusion is complete

If infusion-related reaction:

- 1) STOP infusion immediately
- 2) Begin primary infusion to wide open rate
- 3) Notify MD
- 4) Monitor vital signs
- 5) Administer PRN medications
- 6) 30 minutes after symptoms have resolved, restart infusion at 50% of rate when reaction occurred

Note any changes to above regimen:

 Weekly or Other Dosing (Non-MS Indications)
riTUXimab-arrx in 0.9% sodium chloride IV infusion

[select one] **Dose:** 375 mg/m² Other: _____

Route: Intravenous

[select one] **Frequency:** Once weekly for 4 weeks Other: _____

Infusion Rate (first dose):

- 50 - 400 mg/hr, titrated
- Initiate infusion rate at 50 mg/hr
- Slowly increase in increments of 50 mg/hr every 30 min to max of 400 mg/hr if no reaction

Infusion Rate (subsequent doses):

- 125 - 400 mg/hr, titrated
- Initiate infusion rate at 125 mg/hr
- For subsequent infusions (if no previous infusion reaction): START at 125 mg/hr for 30 min, then 300 mg/hr for 30 minutes, then 400 mg/hr (MAX) until infusion is complete

If infusion-related reaction:

- 1) STOP infusion immediately
- 2) Begin primary infusion to wide open rate
- 3) Notify MD

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- 4) Monitor vital signs
- 5) Administer PRN medications
- 6) 30 minutes after symptoms have resolved, restart infusion at 50% of rate when reaction occurred

Note any changes to above regimen:

 MS Only: Induction Infusion
riTUXimab-arrrx in 0.9% sodium chloride IV infusion

[select one] **Dose:** 1000 mg 500 mg

Route: Intravenous

Frequency: Once

Infusion • 50 - 400 mg/hr, titrated

Rate: • Initiate infusion rate at 50 mg/hr

- Slowly increase in increments of 50 mg/hr every 30 min to max of 400 mg/hr if no reaction

If infusion-related reaction:

- 1) PAUSE infusion immediately
- 2) Begin primary infusion to wide open rate
- 3) Monitor vital signs, document the specific symptom(s) of the reaction
- 4) Consider administering PRN medication(s) as appropriate based on the severity of the reaction
- 5) Once symptoms have resolved, restart infusion at 50% of rate when reaction occurred
- 6) Notify (call/page) MD if a severe infusion reaction occurs
- 7) Draw tryptase lab within 1 hour of reaction

Note any changes to above regimen:

 MS Only: Maintenance Infusion
riTUXimab-arrrx in 0.9% sodium chloride IV infusion

[select one] **Dose:** 500 mg Other: _____

Route: Intravenous

[select one] **Frequency:** Once Every 24 weeks Other: _____

Infusion Rate:

- 125 - 400 mg/hr, titrated
- Initiate infusion rate at 125 mg/hr
- For maintenance infusions (if no previous infusion reaction): START at 125 mg/hr for 30 min, then 300 mg/hr for 30 minutes, then 400 mg/hr (MAX) until infusion is complete

If infusion-related reaction:

- 1) PAUSE infusion immediately
- 2) Begin primary infusion to wide open rate
- 3) Monitor vital signs, document the specific symptom(s) of the reaction
- 4) Consider administering PRN medication(s) as appropriate based on the severity of the reaction
- 5) Once symptoms have resolved, restart infusion at 50% of rate when reaction occurred
- 6) Notify (call/page) MD if a severe infusion reaction occurs
- 7) Draw tryptase lab within 1 hour of reaction

Note any changes to above regimen:

Pre-Meds
 acetaminophen (TYLENOL) tablet

Dose: 650 mg

Route: Oral

Frequency: Once, 30 minutes prior to riTUXimab infusion

May also be given once as needed during infusion for achiness, headache, or fever.

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RiTUXImab
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<input checked="" type="checkbox"/>	cetirizine (ZYRTEC) tablet <i>Dose:</i> 10 mg <i>Route:</i> Oral <i>Frequency:</i> Once, 30 minutes prior to riTUXImab infusion (if not taken at home).
<input checked="" type="checkbox"/>	methylPREDNISolone sodium succinate (SOLU-MEDROL) injectable <i>Dose:</i> 125 mg <i>Route:</i> Intravenous <i>Frequency:</i> Once, 30 minutes prior to riTUXImab infusion [MS induction dose ONLY] methylPREDNISolone sodium succinate (SOLU-MEDROL) injectable <i>Dose:</i> 250 mg <i>Route:</i> Intravenous <i>Frequency:</i> Once, 30 minutes prior to MS induction riTUXImab infusion
<input type="checkbox"/>	Other: _____ <i>Dose:</i> _____ <i>Route:</i> Oral <i>Frequency:</i> Once, 30 minutes prior to riTUXImab infusion
IV Line Care	
<input checked="" type="checkbox"/>	0.9% sodium chloride infusion 250 mL <i>Rate:</i> 30 mL/hr <i>Route:</i> Intravenous <i>Frequency:</i> Run continuously to keep vein open. Start peripheral IV if no central line
PRN & Hypersensitivity Reaction Medications	
<input checked="" type="checkbox"/>	acetaminophen (TYLENOL) tablet <i>Dose:</i> 650 mg <i>Route:</i> Oral <i>Frequency:</i> Take 650 mg PO every 4 hours PRN for fever (greater than 100.4 F), myalgias, arthralgias or headache.
<input checked="" type="checkbox"/>	alteplase (CATHFLO ACTIVASE) injection <i>Dose:</i> 2 mg <i>Route:</i> Intracatheter <i>Frequency:</i> Instill 2 mg to affected port(s) of central venous catheter if sluggish or occluded. Allow to dwell for 30 minutes, if unable to aspirate blood allow to dwell for an additional 90 minutes. May repeat one time if unsuccessful.
<input checked="" type="checkbox"/>	diphenhydrAMINE (BENADRYL) injectable <i>Dose:</i> 50 mg <i>Route:</i> Intravenous <i>Frequency:</i> Once PRN for urticaria, pruritus, shortness of breath. May repeat one time in 15 minutes if symptoms not resolved. Notify provider if patient experiences a hypersensitivity reaction.
<input checked="" type="checkbox"/>	famotidine (PEPCID) (PF) injection <i>Dose:</i> 20 mg <i>Route:</i> Intravenous <i>Frequency:</i> Give IV push over 2 minutes for hives, rash, itching, flushing, and/or swelling in a suspected hypersensitivity reaction. Give immediately after diphenhydrAMINE. Notify provider if patient experiences a hypersensitivity reaction.
<input checked="" type="checkbox"/>	MethylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF) <i>Dose:</i> 125 mg <i>Route:</i> Intravenous <i>Frequency:</i> Once PRN for hypersensitivity reaction. Notify provider if patient experiences a hypersensitivity reaction.
<input checked="" type="checkbox"/>	sodium Chloride 0.9% IV bolus <i>Dose:</i> 1000 mL <i>Route:</i> Intravenous <i>Frequency:</i> Give IV over 1 hour one time PRN for hypotension due to presumed anaphylaxis. Notify provider if patient experiences a hypersensitivity reaction.
<input checked="" type="checkbox"/>	EPINEPHrine (Epi-Pen) 0.3 mg/0.3 mL IM Auto-Injector <i>Dose:</i> 0.3 mg <i>Route:</i> Intramuscular <i>Frequency:</i> Once PRN for anaphylaxis. Give IM one time for severe cardiovascular or respiratory symptoms (e.g. dyspnea, wheeze/bronchospasm, stridor, hypoxemia) of a suspected hypersensitivity reaction. Provider must be present upon given medication.
<input checked="" type="checkbox"/>	meperidine (DEMEROL) injectable <i>Dose:</i> 25 mg <i>Route:</i> Intravenous <i>Frequency:</i> Once PRN, May repeat x1 for shaking chills or rigors. May repeat in 15 minutes if symptoms not resolved.
Nursing Orders	
<ul style="list-style-type: none"> • Verify that patient meets the lab parameters for administration. • MS ONLY: STOP- RN must ask patient if they had any vaccines within the past 28 days before releasing the orders. If vaccines received, contact prescriber. 	

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- Contact the prescribing provider prior to the infusion if the patient has evidence of an active infection.
- Contact the prescribing provider prior to the infusion if ANC is less than 1,500/mm³ or IgG is less than 500 mg/dL.
- Perform assessment for toxicity and tolerance.
- Discontinue IV line when therapy complete and patient stabilized.
- Review discharge medications, instructions, and future appointments.

References

RIABNI™ (riTUXimab-arrx) Injection, for Intravenous Use Prescribing Information

Kaiser Permanente Infusion Locations

Please refer to the link below for the current list:

<https://wa-provider.kaiserpermanente.org/patient-services/ambulatory-infusion>

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____