

**RiTUXimab**  
**Infusion Therapy Plan Orders**

Page 1 of 4

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:

<input type="checkbox"/> Pre-Service Authorization has been obtained by Kaiser Permanente	<b>Fax:</b> 1-888-282-2685	<b>Voice:</b> 1-800-289-1363
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<b>Order Date:</b> _____	<b>Diagnosis</b> ICD-10 code (REQUIRED): _____
<b>Weight:</b> _____ kg	ICD-10 description: _____

**General Plan Communication**

- Biosimilar riTUXimab-arx is the preferred and defaulted agent in this plan
- **Standard Dosing:** Administered as 2 doses of 500-1000 mg, two weeks apart (Day 1 and Day 15)
- **Weekly Dosing:** Administered at 375 mg/m<sup>2</sup> 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 – 12 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 Allergy/Asthma 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
- 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

**Monitoring Parameters for Subsequent Infusions**

- **Timing:** Within 1 month prior to infusion day (if subsequent infusions are scheduled more than 4 weeks apart)
- CBC with differential
- Immunoglobulins (IgG, IgM, IgA)
- Immunocompetency Panel

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

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Date of Birth: \_\_\_\_\_

**Infusion Therapy**
 **Standard Dosing (Non-MS Indications)**
**riTUXimab-arrx in 0.9% sodium chloride 1 mg/mL IV infusion**
**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):**

- 100-400 mg/hr, titrated
- Initiate infusion rate at 100 mg/hr
- Slowly increase in increments of 100 mg/hr every 30 minutes to max of 400 mg/hr if no reaction

**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 Dosing (Non-MS Indications)**
**riTUXimab-arrx in 0.9% sodium chloride 1 mg/mL IV infusion**
**Dose:**            375 mg/m<sup>2</sup>
**Route:**           Intravenous

**Frequency:**    Once weekly for 4 weeks

**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):**

- 100-400 mg/hr, titrated
- Initiate infusion rate at 100 mg/hr
- Slowly increase in increments of 100 mg/hr every 30 minutes to max of 400 mg/hr if no reaction

**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:**
**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**RiTUXImab**  
**Infusion Therapy Plan Orders**

Name: _____
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**MS Only: Induction Infusion**

**riTUXImab-arrx in 0.9% sodium chloride 1 mg/mL IV infusion**

**Dose:**            1000 mg    500 mg

**Route:**           Intravenous

**Frequency:**   Once

**Infusion Rate:**

- 50-400 mg/hr, titrated

**Note:**

- 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) 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:**

\_\_\_\_\_

**MS Only: Maintenance Infusion**

**riTUXImab-arrx in 0.9% sodium chloride 1 mg/mL IV infusion**

**Dose:**            500 mg

**Route:**           Intravenous

**Frequency:**   Once

**Infusion Rate:**

- 100-400 mg/hr, titrated

**Note:**

- Initiate infusion rate at 100 mg/hr
- Slowly increase in increments of 100 mg/hr every 30 minutes to max of 400 mg/hr if no reaction

**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:**

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Pre-Meds		
<input checked="" type="checkbox"/>	<b>acetaminophen (TYLENOL) tablet</b>	<b>Dose:</b> 650 mg <b>Route:</b> Oral <b>Frequency:</b> Once, 30 minutes prior to riTUXImab infusion. May also be given once as needed during infusion for achiness, headache, or fever.
<input checked="" type="checkbox"/>	<b>cetirizine (ZYRTEC) tablet</b>	<b>Dose:</b> 10 mg <b>Route:</b> Oral <b>Frequency:</b> Once, 60 minutes prior to riTUXImab infusion (if not taken at home)
<input checked="" type="checkbox"/>	<b>methylPREDNISolone sodium succinate (SOLU-MEDROL) injectable</b>	<b>Dose:</b> 125 mg <b>Route:</b> Intravenous <b>Frequency:</b> Once, 30 minutes prior to riTUXImab infusion
<input checked="" type="checkbox"/>	<b>Other:</b> _____	<b>Dose:</b> _____ <b>Route:</b> Oral <b>Frequency:</b> Once, 30 minutes prior to riTUXImab infusion

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IV Line Care		
<input checked="" type="checkbox"/>	<b>0.9% sodium chloride infusion 250 mL</b> <i>Rate: 30 mL/hr    Route: Intravenous    Frequency: Run continuously to keep vein open. Start peripheral IV if no central line</i>	
Infusion Reaction Meds		
<input checked="" type="checkbox"/>	<b>albuterol (PROVENTIL) nebulizer solution 0.083%</b> <i>Dose: 2.5 mg    Route: Nebulization    Frequency: PRN for shortness of breath/wheezing</i>	
<input checked="" type="checkbox"/>	<b>diphenhydramine (BENADRYL) injectable</b> <i>Dose: 25 mg    Route: Intravenous    Frequency: Once PRN, May repeat x 1 for urticaria, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.</i>	
<input checked="" type="checkbox"/>	<b>EPINEPHrine (Epi-Pen) 0.3 mg/0.3 mL IM Auto-Injector</b> <i>Dose: 0.3 mg    Route: Intramuscular    Frequency: Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5-inch needle for patients with BMI greater than 30. Notify physician if administered.</i>	
<input checked="" type="checkbox"/>	<b>MethylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF)</b> <i>Dose: 125 mg    Route: Intravenous    Frequency: Once PRN for hypersensitivity reaction. Notify MD upon giving medication</i>	
<input checked="" type="checkbox"/>	<b>meperidine (DEMEROL) injectable</b> <i>Dose: 25 mg    Route: Intravenous    Frequency: Once PRN, May repeat x1 for shaking chills or rigors. May repeat in 15 minutes if symptoms not resolved.</i>	
Nursing Orders		
<ul style="list-style-type: none"> <li>• RN to ensure baseline labs have been completed prior to administration of first dose</li> <li>• Contact the prescribing provider prior to the infusion if the patient has evidence of an active infection.</li> <li>• Contact the doctor prior to the infusion if ANC is less than 1,500/mm<sup>3</sup> or IgG is less than 500 mg/dL.</li> <li>• Discontinue IV line when therapy complete and patient stabilized.</li> </ul>		
References		
RIABNI™ (rituximab-arrx) Injection, for Intravenous Use Prescribing Information		
Kaiser Permanente Infusion Locations		
<b>Bellevue Medical Center</b> 11511 NE 10th St, Bellevue, WA 98004 Fax: 425-502-3811    Phone: 425-502-3820	<b>Olympia Medical Center</b> 700 Lilly Road N.E., Olympia, WA 98506 Fax: 360-923-7609    Phone: 360-923-7600	<b>Silverdale Medical Center</b> 10452 Silverdale Way NW, Silverdale, WA 98383 Fax: 360-307-7421    Phone: 360-307-7316
<b>Capitol Hill Medical Center</b> 201 16th Ave E, Seattle WA 98112 Fax: 206-326-3624    Phone: 206-326-3180	<b>Riverfront Medical Center</b> W 322 North River Drive, Spokane, WA 99201 Fax: 509-434-3184    Phone: 509-324-6464	<b>Tacoma Medical Center</b> 209 Martin Luther King Jr Way, Tacoma, WA 98405 Fax: 253-596-3351    Phone: 253-596-3350
<b>Everett Medical Center</b> 2930 Maple St, Everett, WA 98201 Fax: 425-261-1578    Phone: 425-261-1566		

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