KAISER PERMANENTE®

RiTUXimab

Infusion Therapy Plan Orders

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-arrx 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/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 – 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:**

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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:** __________

Name: ____________________

Kaiser Permanente Member I.D. #: ____________________

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:

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☐ **Weekly Dosing (Non-MS Indications)**

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

Dose: □ 375 mg/m^2

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:** ____________

Name: ______________________________

Kaiser Permanente Member I.D. #: ______________

Date of Birth: ___________________________

☐ **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
- 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
- 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

☒ **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.

☒ **cetirizine (ZYRTEC) tablet**

Dose: 10 mg ***Route:*** Oral ***Frequency:*** Once, 60 minutes prior to riTUXimab infusion (if not taken at home)

☒ **methylPREDNISolone sodium succinate (SOLU-MEDROL) injectable**

Dose: 125 mg ***Route:*** Intravenous ***Frequency:*** Once, 30 minutes prior to riTUXimab infusion

☒ **Other:** ____

Dose: _________ ***Route:*** Oral ***Frequency:*** Once, 30 minutes prior to riTUXimab infusion

Provider Signature: ________________________________ **Date:** ______________________

Printed Name: ________________________________ **Phone:** ____________ **Fax:** ____________

Name: ______________________________

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IV Line Care

☒ **0.9% sodium chloride infusion 250 mL**

Rate: 30 mL/hr | ***Route:*** Intravenous | ***Frequency:*** *Run continuously to keep vein open. Start peripheral IV if no central line*

Infusion Reaction Meds

☒ **albuterol (PROVENTIL) nebulizer solution 0.083%**

Dose: 2.5 mg | ***Route:*** Nebulization | ***Frequency:*** PRN for shortness of breath/wheezing

☒ **diphenhydrAMINE (BENADRYL) injectable**

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.

☒ ***EPINEPHrine (Epi-Pen) 0.3 mg/0.3 mL IM Auto-Injector***

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.*

☒ ***MethylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF)***

Dose: 125 mg | ***Route:*** Intravenous | ***Frequency:*** Once PRN for hypersensitivity reaction. Notify MD upon giving medication

☒ **meperidine (DEMEROL) injectable**

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.

Nursing Orders

- RN to ensure baseline labs have been completed prior to administration of first dose
- Contact the prescribing provider prior to the infusion if the patient has evidence of an active infection.
- Contact the doctor prior to the infusion if ANC is less than 1,500/mm3 or IgG is less than 500 mg/dL.
- Discontinue IV line when therapy complete and patient stabilized.

References

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

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3811 **Phone:** 425-502-3820

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-3624 **Phone:** 206-326-3180

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1578 **Phone:** 425-261-1566

Olympia Medical Center
700 Lilly Road N.E., Olympia, WA 98506
Fax: 360-923-7609 **Phone:** 360-923-7600

Riverfront Medical Center
W 322 North River Drive, Spokane, WA 99201
Fax: 509-434-3184 **Phone:** 509-324-6464

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7421 **Phone:** 360-307-7316

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-596-3351 **Phone:** 253-596-3350

Provider Signature: ______________________________ **Date:** ____________________

Printed Name: ______________________________ **Phone:** __________ **Fax:** __________