

# McLeod Health

## Rituximab (Ruxience, Truxima) Treatment Plan (Non-Oncology)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ Allergies: \_\_\_\_\_

Patient Primary Phone Number: \_\_\_\_\_

### Diagnosis:

- ICD 10 Code: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

### Pre-Medications: \*\*administered 30 minutes prior to infusion\*\*

None

Acetaminophen 650 mg PO

Diphenhydramine: Dose:  25 mg  50 mg Route:  PO or  IVP

Methylprednisolone: Dose:  40 mg or  125 mg Route: IVP

Famotidine: Dose: 20 mg Route:  PO or  IVPB

Other (include drug, dose, and route): \_\_\_\_\_

### Drug Orders:

- Rituximab (Q5119 or Q5115) in Sodium Chloride 0.9% to a concentration of 1 mg/mL IV to infuse per protocol

• Dose:  1000 mg  375 mg/m<sup>2</sup>  Other: \_\_\_\_\_

• Frequency:  Once weekly x 4 doses

Once every 2 weeks x 2 doses

Other: \_\_\_\_\_

• Order Duration: One year unless otherwise specified (Other: \_\_\_\_\_)

• Patient Appropriate for Rapid-Infusion Rituximab:  Yes  No

### Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.
- Appropriate access and line care orders per health system policy

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Lab Orders:**

\_\_\_\_\_

**Pre-Screening Requirements:**

- Provide Hepatitis screening (Hepatitis B Surface Antigen and Hepatitis B core antibody) prior to start of therapy

**Previous Therapies:**

- For new patient referrals, please send history and physical and most recent physician note with completed plan

• If patient has previously received rituximab at another facility, please provide last date received: \_\_\_\_\_

• If patient has previously received another biologic therapy, please provide the name: \_\_\_\_\_

and the last date received: \_\_\_\_\_

**Insurance Information:**

Insurance Plan Name: \_\_\_\_\_

Insurance Identification Number: \_\_\_\_\_

Insurance Customer Service Contact Number: \_\_\_\_\_

**Preferred Treatment Location**

McLeod Regional Medical Center (Florence)  McLeod Health Loris

McLeod Health Cheraw

McLeod Health Seacoast (Little River)

McLeod Health Dillon

McLeod Health Clarendon (Manning)

**Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at [medicationaccessteam@mcleodhealth.org](mailto:medicationaccessteam@mcleodhealth.org).**