PROVIS

| Provis Patient No. |
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# MEDICATION ORDER FORM

## Rituximab (Rituxan®)

| Patient's Surname Given Name & Initials | Date of Birth<br>_____ / _____ / _____<br>dd mm yyyy |
|---|---|
| Referring Physician | |

| Patient's<br>Height: _____ cm<br><br>Weight: _____ kg<br><br>BSA: _____ $m^2$ | Cycle: …… |
|---|---|

**Pre-Medication**

☐ Acetaminophen 650 mg PO 30-60 minutes pre-rituximab
☐ Diphenhydramine 50 mg PO/IV 30-60 minutes pre-rituximab
☐ Other ……

- Hydration/IV solution: NS TKVO on day 1 of each cycle
- Monitor vitals (BP, pulse, respiration, temperature) every 15 mins. For the 1st hour or until stable and then every hour until infusion completed. Have an adverse reaction kit available. Keep IV line in and observe Pt for 1 hr after end of infusion. If complications occur during infusion, observe patient for 2 hrs. after the end of infusion. If Pt experiences transient fevers or rigors during infusion, STOP infusion and observe. Inform physician and treat as ordered. Once stable, restart infusion at ONE-HALF the previous rate.

**Medication prescribed:**

☐ **Rituximab …….. mg (375 mg/$m^2$) IV in 500 mL NS weekly for 4 weeks**

**Or** ☐ **Rituximab ……mg (375 mg/$m^2$ or……mg/$m^2$) IV in 500 mL NS q …….days**
(Please circle or indicate desired dose)

**Or** ☐ **Rituximab (Rituxan®) 1000 mg IV in NS (1 mg/mL) on Days 1 and 15.**
(Scheduling may dictate slight variation from day15)

**Please note: If treatment administered on q 3 wkly schedule a new medical order form is required each cycle.**

**Scheduling (For Provis Use Only)**

Tx 1: _____ Tx 2:_____

Tx 3:_____ (if necessary) Tx 4:_____ (if necessary)

| **Referring Physician's Signature** | _____ / _____ / _____<br>dd mm yyyy |
|---|---|
| **Signature of Provis Physician** | _____ / _____ / _____<br>dd mm yyyy |

**Fax completed form to: 416-532-3635**



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**Information for Physicians**
regarding
**Rituxan® (Rituximab) Infusion at Provis Infusion Clinic**

Thank you for allowing Provis to assist in your patient's care.

We would like to make the coordination of systemic therapy at the Provis Clinic and your facility as easy and seamless as possible for both you and your patient.

Our Clinic Administrator will be in contact with your office to confirm this date.

Rituxan® infusions are given by variable schedules and doses depending upon indication.

1. Please download and complete the **Medication Order Form** for Rituxan® available from our website www.provis.ca FAX to 416-532-3635.

2. In all cases a CBC and chemistry are required within 2 weeks of commencing Rituxan®. In some instances high circulating white cell counts may alter planned schedule or date of initiation of Rituxan®.

3. Where there exist significant co-morbidities or high white cell counts, direct communication with the Provis medical director is important.

If there are any questions or concerns, please do not hesitate to contact our office at Tel. 416-595-0500.

The Provis Team


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