BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: ___/___/_____ Date of Last Infusion: ___/___/_____
Height_____Weight_____

Infusion Location: (state and site) _____

Rituximab and Biosimilars Infusion Orders

☐ MD approves of drug selection based on Insurance requirements (Rituxan, Ruxience, Truxima)
☐ MD wants a specific drug used only Drug _____

Diagnosis (please provide ICD-10 code in space provided):

☐ Non-Hodgkin's Lymphoma ☐ Chronic Lymphocytic Leukemia
☐ Rheumatoid Arthritis ☐ Other: _____

Nursing Orders:

- Hold infusion and notify provider for:
  - Signs/symptoms of infection, surgical procedures, vaccines, neurological changes
- If an infusion-related reaction occurs, stop infusion and initiate Hypersensitivity Reaction Management Protocol Prior to infusion

☐ Hep B negative	☐ CBC with diff	☐ Renal Function	☐ _____

Pre-medications (to be administered once *30 minutes prior* to infusion):

Must use Tylenol 500 mg PO	Must use with RA Solu-Medrol 125 mg IVP	☐ Loratadine 10 mg PO
Must use Benadryl 25 mg PO	☐ Other: _____	☐ Other: _____

Dosing:

☐ Administer rituximab _____mg	
☐ Rituximab _____mg/m² x (current BSA) _____ = _____mg	
☐ To PROHIBIT dose rounding, check here (Dose will be rounded by up to 10% to nearest 100 mg per protocol)	
Doses less than 500mg go in final volume 250ml ml NS, Doses greater than 500 mg go in final volume 500 ml NS	
☐ Infuse on Day 0 and Day 14	☐ Infuse on Day 0, Day 7, Day 14 and Day 21
☐ Other: _____	
☐ Repeat dosing in _____weeks	☐ Repeat dosing in _____onths
☐ Other: _____	

Titrate infusion rates as follows:

Hour	Initial Infusion		Subsequent Infusions (if previously tolerated)	
0	25 ml	50 mg/hr	50 ml	100 mg/hr
0.5	50 ml	100 mg/hr	100 ml	200 mg/hr
1	75 ml	150 mg/hr	150 ml	300 mg/hr
1.5	100 ml	200 mg/hr	200 ml	400 mg/hr
2	125 ml	250 mg/hr		
2.5	150 ml	300 mg/hr		
3	175 ml	350 mg/hr		
3.5	200 ml	400 mg/hr		
Vital signs: Pre-infusion, then with each rate change (at least every 30 minutes) until complete				

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____

Reviewed 4/24/23. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.