

Name: \_\_\_\_\_  
MRN: \_\_\_\_\_  
DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Time: \_\_\_\_\_

Diagnosis:  Rheumatoid Arthritis  Other: \_\_\_\_\_

Age: \_\_\_\_\_ Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ BSA (m<sup>2</sup>): \_\_\_\_\_

**ALLERGIES/Sensitivities:**  NKDA or  \_\_\_\_\_

**Start Date** (at least 1 wk from today): \_\_\_\_\_  **Urgent (Call Infusion Center)**

**Day 1:** \_\_\_\_\_  **Day 1 & 15:** \_\_\_\_\_

**Treatment Department:**  EHW OP Infusion

**Appointment Requests:** Tolerance:  Use default, for chronic treatments order valid for 1 year

Appointment Request – Infusion (**for first dose**) – 6 hours  Start Date \_\_\_\_\_

Appointment Request – Infusion (**for subsequent doses**) – 4 hours  Day 15: \_\_\_\_\_

**Treatment Conditions:** Administer Treatment if  Once on Day 1

Hep B Surface Antigen and Hep B core antibody nonreactive (within 365 days)

Okay to treat. Order Details: \_\_\_\_\_

**Labs:**  Once on Day 1

- CBC & Diff
- Comprehensive Metabolic Panel
- Anti double stranded DNA
- C3 Complement Level
- C4 Complement Level
- Urinalysis Microscopic
- Creatinine Urine Random
- Protein Urine Random
- Creatine Kinase
- Aldolase
- C-reactive protein
- Sedimentation Rate

**\*All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below\***

**Licensed Medical Professional**

Print Name: \_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_  
Contact # \_\_\_\_\_

**Attending Physician**

Print Name: \_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_  
Contact # \_\_\_\_\_

Name: \_\_\_\_\_  
MRN: \_\_\_\_\_  
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**Pre-Medications:**  Order will be done as per appointment frequency  
 Instructions: Give at treatment start time

- Acetaminophen tablet 650 mg, oral, Once
- DiphenhydrAMINE, once,  25mg  50mg,  tablet, Oral
- Famotidine, 20mg, once (choose one)  tablet, Oral  injection, IV
- Ondansetron, 4 mg, once (choose one)  tablet, Oral  injection, IV
- Hydrocortisone sodium succinate (Solu- CORTEF) injection 100 mg, intravenous, once
- Montelukast (Singular) tablet 10 mg, oral
- MethylPREDNISolone sodium succinate (PF) (SOLU-Medrol) injection 40 mg intravenous, once

**Chemotherapy:**  Day 1  Day 1 & 15

- Normal Saline 0.9% 250mL, Prime Bag
- RiTUXimab or biosimilar (select one)**
  - Flat Dose: 500 mg IV in 500 mL NS (1 mg/mL) to be given at 60 minutes after treatment start time
  - Flat Dose: 1000 mg IV in 1000 mL NS (1 mg/mL) to be given at 60 minutes after treatment start time
  - \_\_\_\_\_ mg (375 mg/m<sup>2</sup>) IV mixed in NS to a final concentration of 1 mg/mL

**Infusion Rate**

- First Dose:** Titrate infusion beginning at 50 mg/hr and escalate by 50 mg/hr every 30 minutes to a maximum rate of 400 mg/hr if no reaction occurs.
- Subsequent Doses:** Titrate infusion beginning at 100 mg/hr and escalate by 100 mg/hr every 30 minutes to a maximum rate of 400 mg/hr.

**Emergency Medications**  Order will be done as per appointment frequency

- Hypersensitivity reaction protocol  
Protocol Document: <https://emory.ellucid.com/documents/view/15307/15641>

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Signature \_\_\_\_\_  
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**Attending Physician**

Print Name: \_\_\_\_\_  
Signature \_\_\_\_\_  
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