University Hospitals of Derby and Burton
NHS Foundation Trust

RITUXIMAB INFUSION DOCTOR'S CHECKLIST (TRUXIMA)

(To be used in conjunction with the Renal Rituximab guideline)

AFFIX PATIENT LABEL
Name:
Hospital No:

DOB:

Date: …….

Indication For Rituximab ……

INDUCTION DOSE

Dose Number (Circle one): 1 2

Patient has been provided with PIL and has had the opportunity to ask questions Yes ☐

Specifically, they are aware of:

1. The need for PCP prophylaxis Yes ☐
2. Pregnancy/contraception/breastfeeding (Advise effective contraception for 12 months) Yes / NA
3. Rituximab alert card and advice in event of illness Yes ☐
4. Patient gives verbal consent to treatment with Rituximab today Yes ☐

The Patient is well today with no signs or symptoms of active infection Yes ☐

The patient is up to date with recommended vaccinations (*pneumococcal/ influenza/ COVID*) Yes / No

If No Document reason for proceeding without vaccination…….

PCP prophylaxis has been prescribed (see Rituximab guideline) Yes ☐

Has the patient had any previous documented adverse infusion reactions/Drug allergies Yes / No

If Yes Document reaction and management plan for this infusion ……

……

……

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The following test results are available and have been reviewed

	Date	Tick if normal	Abnormal results and Action (please discuss with consultant)
FBC/U+E/LFT/CRP			
Hepatitis B sAg			If positive check Hep B DNA and refer to Trust guideline on hepatitis B reactivation on Immunosuppressive therapy. Consultant decision to proceed.
Anti HBs			
Anti HBc			If anti-HBc positive, please prescribe lamivudine prophylaxis for minimum of 6 months, send Hep B DNA (purple tube) and inform patient of small risk of Hep B reactivation. Consultant decision to proceed.
Hepatitis C Antibody			
HIV			
Immunoglobulins			
VZV IgG (Advise contact risks if negative)			
Vaccinations – pneumococcal/ influenza/ COVID vaccines (Recommended a minimum of 4 weeks pre infusion)			
CXR within last 6 months			
IGRA test (only if high risk for TB, defined as from country with TB prevalence >40 per 100,000 or household contact of TB https://www.gov.uk/government/publications/tuberculosis-tb-by-country-rates-per-100000-people)			

I confirm there is no contraindication to Rituximab treatment today

Signature: Name:	Date: Time:

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RITUXIMAB INFUSION DOCTOR'S CHECKLIST (TRUXIMA)

(To be used in conjunction with the Renal Rituximab guideline)

AFFIX PATIENT LABEL **Name:** **Hospital No:** **DOB:**

Date: …….

Indication For Rituximab ……

MAINTENANCE DOSE 1 2 3 ……

Patient has been provided with PIL and has had the opportunity to ask questions Yes ☐

Specifically, they are aware of:

1. The need for PCP prophylaxis Yes ☐
2. Pregnancy/contraception/breastfeeding (Advise effective contraception for 12 months) Yes / NA
3. Rituximab alert card and advice in event of illness Yes ☐
4. Patient gives verbal consent to treatment with Rituximab today Yes ☐

The Patient is well today with no signs or symptoms of active infection Yes ☐

The patient is up to date with recommended vaccinations (*pneumococcal/ influenza/ COVID*) Yes / No

If No Document reason for proceeding without vaccination……

……

PCP prophylaxis has been prescribed (see Rituximab guideline) Yes ☐

Has the patient had any previous documented adverse infusion reactions/Drug allergies Yes / No

If Yes Document reaction and management plan for this infusion ……

……

……

The following test results are available and have been reviewed

	Date	Tick if normal	**Abnormal results and Action (please discuss with consultant)**
FBC/U+E/LFT/CRP			
Immunoglobulins			(Consider delay/reduce dose if low levels)
CXR within last 12 months (at Consultant discretion)			

I confirm there is no contraindication to Rituximab treatment today

Signature: Name:	Date: Time:

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