

**Pediatric Rituxan Infusion Order** (Revised 4/3/21)

**Instructions to Provider:** All orders with  will be placed unless otherwise noted. Please fax completed order, along with referral form to desired location.

**Required Lab Results:** Prior to first infusion Hep B and PPD/Quantiferon Gold, CBC with diff within 90 days (if outside of Atrium, please fax with order. Required prior to scheduling)

**Infusion Therapy:**

Rituxan (rituximab) \_\_\_\_\_ mg IV

ICD 10 code: \_\_\_\_\_

Once

Day 1 and Day 15

**Frequency:** every \_\_\_\_\_ months

**Pre-Meds: Administer 30 minutes prior to Rituxan**

Acetaminophen \_\_\_\_\_ mg PO x 1

Benadryl \_\_\_\_\_ mg PO or \_\_\_\_\_ mg IV x 1 (*if applicable, only choose ONE*)

SoluMedrol \_\_\_\_\_ mg IV x 1

Loratadine \_\_\_\_\_ mg PO x 1

EMLA cream prior to IV start

**Anaphylaxis Medications:**

Epinephrine (1:1000) \_\_\_\_\_ mg SQ/IM; may be repeated after 5mins

SoluMedrol \_\_\_\_\_ mg IV

Benadryl \_\_\_\_\_ mg IV

**Additional Orders:**

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**Special Instructions:**

- Infusion rates:
  - Start infusion at 50mg/hr, after 60mins, increase by 50mg/hr every 30mins to a maximum 400mg/hr unless infusion completed.
  - If no adverse event with previous infusion, start at 100mg/hr. Increase rate by 100mg/hr every 30mins to a maximum 400mg/hr unless toxicity occurs.
- Infusion Monitoring:
  - Vital Signs: Obtain Vital Signs every 15mins x 2 then every hour during the infusion
  - Monitor for 30mins after completion of infusion.
- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.

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

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

Date: \_\_\_\_\_ (Order valid for 1 year)

Patient Name:

DOB:

MRN: