Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Pediatric Truxima 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:

☐ Truxima (rituximab-abbs)______mg IV **ICD 10 code: _______**

☐ Once

☐ Day 1 and Day 15

☐ **Frequency:** every _______months

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

☐ 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:

____

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: