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

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.

Required Lab Results: Hep B Profile prior to first infusion and CBC with diff within 90 days of Day 1 infusion of every cycle (If outside of Atrium, please fax with order. Required prior to scheduling.)

Infusion Therapy:

☐ Truxima (rituximab-abbs) _____mg x2 doses (Day 1 and Day 15) and every _____months

☐ Truxima (rituximab-abbs) _____ (375mg/m^2) **Frequency: _____**

☐ Truxima (rituximab-abbs) _____ mg x 1 dose **Frequency: _____**

Pre-Meds: **ICD 10 code: _____**

Administer 30 minutes prior to Truxima

☒ Acetaminophen **_1000_** mg PO x 1

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

☒ SoluMedrol **_125__** mg IV x 1

PRN Medications:

☒ Acetaminophen 500mg PO every 4 hours PRN pain (give first)

☒ Zofran 4mg IV every 3 hours PRN nausea/vomiting

☒ Ibuprofen 800mg PO x 1 PRN pain (give second)

Additional Orders:

_____

Special Instructions:

- **Fluid/Volume: Normal Saline 0.9% for 1:1 concentration**
- **Initial infusion rates:** 50mg/hour x30 minutes. If tolerated increase the rate by 50 mg/hour every 30 minutes as tolerated to a max rate of 400mg/hour.
- **For subsequent infusions:** start at 100mg/hour for 30 minutes. If patient tolerates the infusion, increase the rate by 100mg/hour every 30 minutes as tolerated to a max rate of 400mg/hour.
- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. Obtain vital signs 30 mins after initiation of infusion, then hourly for the remainder of the infusion, and 30 minutes after 1st infusion and the subsequent infusion PRN.
- Monitor for signs of reaction for 30 mins after completion of the 1st infusion of each cycle and the subsequent infusion PRN if previous signs of reaction observed.

Physician Name: _____
Physician Signature: _____
Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: