Ascension Rx

# Infliximab (Remicade & Biosimilars) Infusion Order Form

**Patient Name:** _____ **Date of Birth:** _____

**Patient Phone #:** _____ **Date:** _____

**Therapy Status:** ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

| Height (inches) | Weight (kg) | Allergies |
|---|---|---|
| | | |

## Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

## Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☐ Baseline
    - ☑ TB screening (QuantiFERON or alternative)
    - ☑ Hepatitis Screening prior to therapy (HBsAg, HepB core Ab total, HCV)
    - ☑ Hepatic Function Panel
  - ☑ Maintenance (every _____)
    - ☑ Hepatic Function Panel
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

## Provider Information

Live vaccines should not be given concurrently

## Nursing Orders

- ☑ Do not administer with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

## Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO, once
- ☐ Diphenhydramine 25 mg PO, once
- ☐ Diphenhydramine 25 mg IV, once
- ☐ Methylprednisolone 125 mg IV, once
- ☐ Methylprednisolone 40 mg IV, once
- ☐ Famotidine 20 mg IV, once
- ☐ Diphenhydramine 50 mg PO, once
- ☐ Diphenhydramine 50 mg IV, once
- ☐ Dexamethasone 20 mg IV, once
- ☐ Dexamethasone 20 mg PO, once

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☐ Other: _____

## IV Site Orders

☑ Follow standard protocol for IV site management
☑ In absence of standard protocol, follow the orders below:
- ☑ Sodium chloride 0.9% infusion 250 mL IV at 20 mL/hr PRN (carrier fluid/KVO)
- ☑ Start peripheral IV or access central line for infusion
- ☑ Sodium chloride 0.9% 10 mL flush to IV site as needed
- ☑ Heparin 50 units/5 mL flush to IV site as needed (central line only)
- ☑ Heparin 500 units/5 mL flush to IV site as needed (central line only)
- ☑ May use alteplase 2 mg intracatheter as needed for negative blood return of IV site

## Medication Orders

☐ Infliximab IV 3 mg/kg (_____ mg) once
☐ Infliximab IV 3 mg/kg (_____ mg) once on week 0, 2, 6 (Induction) and every 8 weeks thereafter (maintenance)
☐ Infliximab IV 3 mg/kg (_____ mg) once every _____ weeks (maintenance)

☐ Infliximab IV 5 mg/kg (_____ mg) once
☐ Infliximab IV 5 mg/kg (_____ mg) once on week 0, 2, 6 (Induction) and every 8 weeks thereafter (maintenance)
☐ Infliximab IV 5 mg/kg (_____ mg) once every _____ weeks (maintenance)

☐ Infliximab IV 10 mg/kg (_____ mg) once
☐ Infliximab IV 10 mg/kg ( _____ mg) once on week 0, 2, 6 (Induction) and every 8 weeks thereafter maintenance)
☐ Infliximab IV 10 mg/kg (_____ mg) once every _____ weeks (maintenance)

☐ Infliximab IV _____ mg once
☐ Infliximab IV _____ mg/kg (_____ mg) once

**Refills:**
**(Refills for one year from date of signature unless indicated)**

☐ Zero ☐ For 12 months ☐ _____

**To be completed by Infusion Center staff only:**

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:
☐ Payer-mandated substitution
☐ Financial stewardship
☐ Patient access / hardship

☐ **60 min Rapid Infusion Rate:** Infuse over 60 min at a rate up to 550 mL/hr, depending on volume of bag. May be infused over 60 min if patient received at least 4 consecutive infliximab (or biosimilar) infusions over 2 hours with no evidence of infusion reaction. Document qualifications prior to administration of 60 min rapid infusion.

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| |
|---|
| ☐ **30 min Rapid Infusion Rate:** Infuse over 30 min at a rate up to 1,100 mL/hr, depending on volume of bag. May be infused over 30 min if patient received at least 4 consecutive infliximab (or biosimilar) infusions over 1 hour with no evidence of infusion reaction. Document qualifications prior to administration of 30 min rapid infusion. |
| Pharmacy may adjust dose ±10% of ordered dose per approved protocol. Pharmacy may substitute a biosimilar based on insurance coverage.<br>Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards. |

## Administration Instructions

Infuse through a ≤ 1.2 micron, low protein binding inline filter.

For the 1st dose and for patients with history of infusion reaction:

**250 mL bag:** Start infusion rate at 10 mL/hr for 15 minutes, then increase to 20 mL/hr for 15 minutes, then 40 mL/hr for 15 minutes, then 80 mL/hr for 15 minutes, then 150 mL/hr for 15 minutes, then 250 mL/hr until infusion complete. For subsequent infusions, may infuse over 2 hrs without titration if tolerated.

**500 mL bag**: Start infusion rate at 20 mL/hr for 15 minutes, then increase to 40 mL/hr for 15 minutes, then 80 mL/hr for 15 minutes, then 160 mL/hr for 15 minutes, then 300 mL/hr for 15 minutes, then 500 mL/hr until infusion complete. For subsequent infusions, may infuse over 2 hrs without titration if tolerated.

## Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, $O_2$ 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
  - ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

## Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

## Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

***All orders are valid for 1 year from the ordered date unless otherwise indicated***