InFLIXimab Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. Patients should not have an active ongoing infection, signs or symptoms of malignancy, or moderate to severe heart failure at the onset of TNF-alpha inhibitor therapy. Baseline liver function tests should be normal.
5. Patient should have regular monitoring for TB, hepatitis B, infection, malignancy, and liver abnormalities throughout therapy.
6. Patients being considered for treatment with infliximab should not have an active ongoing infection. Patients treated with infliximab products are at increased risk for developing serious infections. Monitor for signs and symptoms of infection during and after treatment with infliximab.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- ☐ Hepatitis B surface antigen and core antibody test results scanned with orders.
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- ☐ Antinuclear antibody (ANA) screening (ANA BY ELISA W/REFLEX TO IFA PATTERN A&B ID WHEN INDICATED), Routine, ONCE, prior to initiation of TNF-alpha inhibitor therapy
- ☐ Complete Metabolic Panel, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ HCG Beta, PLASMA, routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Labs already drawn. Date: _____

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. TREAMENT PARAMETER – Hold infusion and contact provider if patient has signs or symptoms of infection.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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4. Infuse over 2 hours for first 4 infusions. If tolerated first 4 infusions well, may infuse rapidly, 100 mL/hr for first 15 minutes and then 300 mL/hr for 45 minutes or until entire bag is infused.
5. For previous infusion reactions, begin all subsequent infusions at 10 mL/hr for 15 minutes, then double the rate every 15 minutes up to a maximum of 125 mL/hr. If tolerated infusion well without need of premeds, discuss with a provider to change infusion rate case by case.
6. Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion, then every 15 minutes x 30 minutes, then every 30 minutes until infusion is completed. Consider observing patient for 60-minute following infusion.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
  Give either loratadine or diphenhydrAMINE, not both.
- ☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. ***Give either loratadine or diphenhydrAMINE, not both.***
- ☐ methylPREDNISolone sodium succinate (SOLU-MEDROL), 40 mg, intravenous, ONCE AS NEEDED if patient has required IV steroids for a reaction during a prior TNF-alpha inhibitor infusion, every visit

Biosimilar selection (must check one) – applies to all orders below

- ☐ INFLECTRA (inFLIXimab-dyyb) ***(OHSU & HMC preferred brand)***
- ☐ REMICADE (inFLIXimab) *Restricted to existing REMICADE patients for continuing therapy*
- ☐ RENFLEXIS (inFLIXimab-abda)
- ☐ AVSOLA (inFLIXimab-axxq)
- ☐ _____

At OHSU clinics, if insurance requires a different biosimilar agent, pharmacy will update the order per CDTM.

- ☐ Only check this box if it is NOT okay to substitute for insurance. Dispense as written (DAW).

MEDICATIONS:

Initial Doses: *(Pharmacist will use most recent weight and round dose to the nearest 100 mg vial)*

- ☐ 3 mg/kg in sodium chloride 0.9%, intravenous
- ☐ 5 mg/kg in sodium chloride 0.9%, intravenous
- ☐ 10 mg/kg in sodium chloride 0.9%, intravenous

Interval: ***(must check one)***

- ☐ Once
- ☐ Three doses at 0, 2, and 6 weeks; dates: Week 0_____, Week 2_____, Week 6_____
- ☐ Other: _____

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Maintenance Doses: *(Pharmacist will use most recent weight and round dose to nearest 100 mg vial)*

- ☐ 3 mg/kg in sodium chloride 0.9%, intravenous
- ☐ 5 mg/kg in sodium chloride 0.9%, intravenous
- ☐ 10 mg/kg in sodium chloride 0.9%, intravenous

Interval:

- ☐ Every _____ weeks for ____ doses

AS NEEDED MEDICATIONS:

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for hypersensitivity or infusion reaction, chills, or malaise.
2. diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching
3. sodium chloride 0.9% solution, intravenous, 500 mL, AS NEEDED x1 dose, for TNF-alpha inhibitor infusion tolerability. Give concurrently with TNF-alpha inhibitor.

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058	Phone (541) 296-7585 Fax (541) 296-7610