ORDERING OFFICE, ALSO FAX:

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

Infliximab (Remicade, Renflexis, Inflectra)

Provider Order Form

OIS Ohio Infusion Services

Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
☐ NKDA Allergies:		Weight lbs/kg:
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:

LABORATORY ORDERS

☐	CBC	☐ every other dose	☐ every _____
☐	CMP	☐ every other dose	☐ every _____
☐	CRP	☐ every other dose	☐ every _____
☐	Other:		

PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ Other:
  Dose: Route: Frequency:

INFUSION THERAPY

- Please check preferred product(s):
  ☐ infliximab (Remicade) ☐ infliximab-abda (Renflexis) ☐ infliximab-dyyb (Inflectra)

☑ Mix in 250ml 0.9% sodium chloride, intravenous infusion over two hours (use in line filter 1.2micron or less)

- Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ Other _____
  ☐ round up to nearest 100mg
  ☐ give exact dose
  Frequency: / ☐ induction: week 0, 2, 6, and then every 8 weeks / ☐ maintenance: every 8 weeks / ☐ other: _____
- Infusion rate
  Increase to:
  10ml/hr x 15min
  20ml/hr x 15 min
  40ml/hr x 15 min
  80ml/hr x 15 min
  150ml/hr x 30 min
  250ml/hr until infusion complete

☑ Flush with 0.9% sodium chloride at the completion of infusion

☐ Patient is required to stay for 30-minute observation post infusion

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

GENERAL PLAN COMMUNICATION

Special instructions/notes:

Ordering Provider: Initial here _____ and proceed to the next page.

ADULT REACTION MANAGEMENT

☐ Observe for **hypersensitivity reaction:** Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
☐ If reaction occurs:

- Stop infusion
- Maintain/establish vascular access
- Notify referring provider
- Consider giving the following PRN
  1. Acetaminophen (Tylenol) 650mg PO **OR**_____mg for pain or fever > 38 C/100.4 F
  2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
  3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
  4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
  5. Methylprednisolone (Solumedrol) 125mg **OR** _____ mg slow IV push.
  6. Other _____
- When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines

☐ **Severe allergic/anaphylactic reaction:**

- If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
  1. Call 911
  2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
  3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
  4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
  5. Have Automated External Defibrillator available
  6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
  7. Discontinue treatment

* Perform test for latent TB; if positive, start treatment for TB prior to starting treatment. Monitor all patients for active TB during treatment, even if initial latent TB test is negative
* Patients should be tested for HBV infection before initiating TNF blocker therapy, including REMICADE. For patients who test positive for hepatitis B surface antigen, consultation with a physician with expertise in the treatment of hepatitis B is recommended.

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

Provider Name (Print) _____

Provider Signature _____ **Date** _____

Please fax the order form to (440) 443-0700

OIS Ohio Infusion Services