Outpatient Infliximab (Inflectra, Remicade) Infusion Order Set

Klickitat Valley Health
Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date *(max one year)* _____

Allergies: _____

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 before starting therapy and must not be older than six months)*:

☐ 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

DIAGNOSIS CODE: **MUST include ICD10 code**

☐ _____

Labs:

☐ Antinuclear antibody screening, Routine, ONCE, prior to initiation of TNF-alpha inhibitor therapy

☐ Basic Metabolic Set, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*

☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*

☐ Liver Set (AST, ALT, BILI TOTAL, BILI DIRECT, ALK PHOS, ALB, PROT TOTAL), 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

☒ 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

☒ TREATMENT PARAMETER: Hold infusion and contact provider if patient has signs or symptoms of infection.

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IV ACCESS: ☐ Place peripheral IV ☐ Access Implanted Port

If nurse to access implanted port please complete Port Access Order Set as well

☒ Vital Signs: 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-minutes following infusion.

☒ Infuse over 2 hours. 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

Pre-Medications *(administer 30 minutes prior to each infusion):*

☐ Acetaminophen (Tylenol) 650mg PO x1 dose ☐ Methylprednisolone (Solu-medrol) 125mg IV x 1 dose

☐ Diphenhydramine (Benadryl) 25mg PO x1 dose

Medication Orders- SELECT ONE, *applies to all orders below*

☐ Inflectra (Infliximab-dyyb)

☐ Remicade (Infliximab)

Dosage Orders-

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

☐ Other: _____

Dosage Orders-

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

MANAGEMENT OF SIDE EFFECTS

☒ In the event of an adverse reaction, which can be characterized by unexpected physiological responses such as a notable decrease in blood pressure, irritation at the injection site, muscle cramps, gastrointestinal distress (nausea and diarrhea), or other concerning symptoms: Hold infusion x 30 mins, if symptoms improve resume infusion at half previous rate, if symptoms persist consider administering 500ml IV sodium chloride 0.9% bolus and call provider. If afterhours call hospitalist.

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IF ANAPHYLACTIC REACTION OCCURS

☒ Stop infusion immediately, notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ 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 _____**

Printed name: _____ **Phone: _____** **Fax: _____**

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date _____**

Printed name: _____

Patient Name:
DOB: