



Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:

- Interval: Every 14 days x 2 treatments, then every 56 days starting on day 42.

Duration:

- Until date: _____
- 1 year
- _____ # of Treatments

Anticipated Infusion Date _____ ICD 10 Code with Description _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Provider Specialty

- Allergy/Immunology Infectious Disease OB/GYN Rheumatology
- Cardiology Internal Med/Family Practice Other Surgery
- Gastroenterology Nephrology Otolaryngology Urology
- Genetics Neurology Pulmonary Wound Care

Site of Service

- SH Gerber SH Lemmen Holton (GR) SH Pennock SH United Memorial
- SH Helen DeVos (GR) SH Ludington SH Reed City SH Zeeland

Appointment Requests

- Infusion Appointment Request

Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs. Verify that all INDUCTION/LOADING DOSES have been scheduled and offset appropriately when scheduling MAINTENANCE DOSES.

Provider Ordering Guidelines

- ONC PROVIDER REMINDER 3

INFLIXIMAB-ABDA (RENFLEXIS) or INFLIXIMAB-DYYB (INFLECTRA) OR INFLIXIMAB (REMICADE):

Premedication is not required, but can be considered for the prevention of subsequent infusion reactions.

Prior to initial INFLIXimab-abda (RENFLEXIS) or INFLIXimab-dyyb (INFLECTRA) or INFLIXimab (REMICADE) infusion, AND ANNUALLY, all patients must have a TB test completed.

All patients should have HBV screening prior to initiating; HBV carriers (during and for several months following therapy)

- ONC PROVIDER REMINDER 21

INFLIXIMAB-ABDA (RENFLEXIS) or INFLIXIMAB-DYYB (INFLECTRA) or INFLIXIMAB (REMICADE) INDUCTION AND MAINTENANCE: **CAUTION - ENSURE APPROPRIATE TIMING OF THERAPY. Usual Induction therapy is administered weeks 0, 2, and 6. The Spectrum Health Therapy Plan for INDUCTION contains weeks 0 and 2. The MAINTENANCE therapy plan starts WEEK 6 and continues every 8 weeks. **ENSURE APPROPRIATE TIMING BETWEEN INDUCTION AND MAINTENANCE PLANS!!**

Safety Parameters and Special Instructions

- ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 6

Verify all INDUCTION/LOADING DOSES given prior to start of MAINTENANCE DOSES

- ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 4

HEPATITIS B VIRUS SURVEILLANCE AND MAINTENANCE RECOMMENDATIONS: Screen prior to treatment. Refer to specialist as warranted by serology.

- ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 5

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

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Safety Parameters and Special Instructions (continued)

TUBERCULOSIS SURVEILLANCE AND MANAGEMENT RECOMMENDATIONS: Screen prior to treatment and annually for continuing therapy. Treat latent infection prior to starting therapy.

Labs

	Interval	Duration
<input checked="" type="checkbox"/> Complete Blood Count w/Differential Status: Future, Expected: S, Expires: S+184, URGENT, Clinic Collect, Blood, Blood, Venous	<input type="checkbox"/> Once <input type="checkbox"/> Every 56 days	<input type="checkbox"/> 1 treatment <input type="checkbox"/> Until date: _____
<input checked="" type="checkbox"/> Basic Metabolic Panel (BMP) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	Once	1 treatment
<input checked="" type="checkbox"/> Hepatic Function Panel (Liver Panel) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	<input type="checkbox"/> Once <input type="checkbox"/> Every 56 days	<input type="checkbox"/> 1 treatment <input type="checkbox"/> Until date: _____
<input checked="" type="checkbox"/> Hepatitis B Surface Antigen Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	<input type="checkbox"/> Once <input type="checkbox"/> PRN	<input type="checkbox"/> 1 treatment <input type="checkbox"/> Until date: _____
<input checked="" type="checkbox"/> Hepatitis B Core Total Antibody Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	<input type="checkbox"/> Once <input type="checkbox"/> PRN	<input type="checkbox"/> 1 treatment <input type="checkbox"/> Until date: _____
<input checked="" type="checkbox"/> Comprehensive Metabolic Panel (CMP)	<input type="checkbox"/> Once <input type="checkbox"/> Every 56 days	<input type="checkbox"/> Until date: _____
<input type="checkbox"/> Other Labs: _____	<input type="checkbox"/> Once <input type="checkbox"/> PRN	<input type="checkbox"/> 1 treatment <input type="checkbox"/> Until date: _____
<input checked="" type="checkbox"/> Arrange For Patient To Have Id Tb Skin Test Administered And Read Or Serum Tb Screening Lab Prior To Therapy Or Annually		
<input type="checkbox"/> ONC PROVIDER REMINDER 28 Arrange for patient to have intradermal TB skin test (tuberculin PPD) screening performed and read prior to initiating therapy and annually.	Once	1 treatment
<input type="checkbox"/> TB Screen (Quantiferon Gold) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	Once	1 treatment

Vitals

- Vital Signs**
Routine, PRN, Starting S For Until specified, Vital Signs Monitoring: Obtain vital signs (patient temperature, blood pressure and pulse) upon arrival, after start of medication, upon discontinuing infusion and before the patient departs the facility. However, if patient has an acute reaction with preceding dose, monitor vitals every 10 minutes for 30 minutes then every 30 minutes and for 30 minutes after infusion.

Nursing Orders

- ONC NURSING COMMUNICATION 1**
INFLIXIMAB-ABDA (RENFLEXIS) OR INFLIXIMAB (REMICADE) OR INFLIXIMAB-DYYB (INFLECTRA):

Notify physician of signs and symptoms of adverse reactions. If reaction occurs, call physician immediately.

Patients receiving infliximab or biosimilars are at increased risk for serious infections. Monitor for signs of infection.
- ONC NURSING COMMUNICATION 100**
May Initiate IV Catheter Patency Adult Protocol

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Nursing Orders (continued)

Treatment Parameters

- ONC MONITORING AND HOLD PARAMETERS 3**
May proceed with treatment if hepatitis B core antibody and surface antigen labs have been resulted prior to the first dose, and the results are negative.

- ONC MONITORING AND HOLD PARAMETERS 4**
May proceed with treatment if tuberculosis screening test with either TB Screen blood test (QuantiFERON® Gold Plus) or TB skin test have been resulted prior to first dose and within one year for continuing therapy, and the results are negative.

Pre-Medications

- acetaminophen (TYLENOL) tablet 650 mg
650 mg, Oral, Once, Starting H, For 1 Doses

- diphenhydrAMINE (BENADRYL) capsule
Dose:
 - 25 mg
 - 50 mg
 Oral, Once, Starting H, For 1 Doses

- methylPREDNISolone sodium succinate (SOLU-Medrol) injection
Dose:
 - 40 mg
 - 80 mg
 - 125 mg

Intravenous, for 30 Minutes, Unscheduled, Starting S, For 1 Doses
Administer 30 minutes before infusion

Induction Treatment

- Select Either Infliximab-abda (renflexis) Or Infliximab-dyyb (inflectra) Or Infliximab (remicade)**

- inFLIXimab-abda (RENFLEXIS) IVPB (**Preferred Formulary Product**)
Dose:
 - 3 mg/kg
 - 5 mg/kg
 - 10 mg/kg
 - ___ mg/kg
 Intravenous, for 2 Hours, Once, Starting H+30 Minutes, For 1 Doses
 Infuse over at least 2 hours. FOR THE FIRST DOSE AND FOR PATIENTS WITH A HISTORY OF INFUSION REACTION: Begin infusion at 10 mL/hr for 15 minutes, then 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 30 minutes, then 250 mL/hr until infusion complete.

FOR SUBSEQUENT INFUSIONS: If patient tolerates infusion, may infuse over 2 hours without titration.
Brand name to dispense per prior authorization (Adult Outpatient Infusion only)?

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Induction Treatment (continued)

- inFLIXimab-dyyb (INFLECTRA) IVPB

Dose:

- 3 mg/kg
- 5 mg/kg
- 10 mg/kg
- ___ mg/kg

Intravenous, for 2 Hours, Once, Starting H+30 Minutes, For 1 Doses

Infuse over at least 2 hours. FOR THE FIRST DOSE AND FOR PATIENTS WITH A HISTORY OF INFUSION REACTION: Begin infusion at 10 mL/hr for 15 minutes, then 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 30 minutes, then 250 mL/hr until infusion complete.

FOR SUBSEQUENT INFUSIONS: If patient tolerates infusion, may infuse over 2 hours without titration.

Brand name to dispense per prior authorization (Adult Outpatient Infusion only)?

- inFLIXimab (REMICADE) IVPB

Dose:

- 3 mg/kg
- 5 mg/kg
- 10 mg/kg
- ___ mg/kg

Intravenous, for 2 Hours, Once, Starting H+30 Minutes, For 1 Doses

Infuse over at least 2 hours. FOR THE FIRST DOSE AND FOR PATIENTS WITH A HISTORY OF INFUSION REACTION: Begin infusion at 10 mL/hr for 15 minutes, then 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 30 minutes, then 250 mL/hr until infusion complete.

FOR SUBSEQUENT INFUSIONS: If patient tolerates infusion, may infuse over 2 hours without titration.

Brand name to dispense per prior authorization (Adult Outpatient Infusion only)?

Maintenance Treatment

- Select Either Infliximab-abda (renflexis) Or Infliximab-dyyb (inflectra) Or Infliximab (remicade)**

- inFLIXimab-abda (RENFLIXIS) IVPB (Preferred Formulary Product)

Dose:

- 3 mg/kg
- 5 mg/kg
- 10 mg/kg
- ___ mg/kg

Intravenous, for 2 Hours, Once, Starting H+30 Minutes, For 1 Doses

Infuse over at least 2 hours. FOR THE FIRST DOSE AND FOR PATIENTS WITH A HISTORY OF INFUSION REACTION: Begin infusion at 10 mL/hr for 15 minutes, then 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 30 minutes, then 250 mL/hr until infusion complete.

FOR SUBSEQUENT INFUSIONS: If patient tolerates infusion, may infuse over 2 hours without titration.

Brand name to dispense per prior authorization (Adult Outpatient Infusion only)?

- inFLIXimab-dyyb (INFLECTRA) IVPB

Dose:

- 3 mg/kg
- 5 mg/kg
- 10 mg/kg
- ___ mg/kg

Intravenous, for 2 Hours, Once, Starting H+30 Minutes, For 1 Doses

Infuse over at least 2 hours. FOR THE FIRST DOSE AND FOR PATIENTS WITH A HISTORY OF INFUSION REACTION: Begin infusion at 10 mL/hr for 15 minutes, then 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 30 minutes, then 250 mL/hr until infusion complete.

FOR SUBSEQUENT INFUSIONS: If patient tolerates infusion, may infuse over 2 hours without titration.

Brand name to dispense per prior authorization (Adult Outpatient Infusion only)?

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inFLIXimab (REMICADE) IVPB
Dose:

Every 56
days

- 3 mg/kg
- 5 mg/kg
- 10 mg/kg
- _____ mg/kg

Intravenous, for 2 Hours, Once, Starting H+30 Minutes, For 1 Doses

Infuse over at least 2 hours. FOR THE FIRST DOSE AND FOR PATIENTS WITH A HISTORY OF INFUSION REACTION: Begin infusion at 10 mL/hr for 15 minutes, then 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 30 minutes, then 250 mL/hr until infusion complete.

FOR SUBSEQUENT INFUSIONS: If patient tolerates infusion, may infuse over 2 hours without titration.

Brand name to dispense per prior authorization (Adult Outpatient Infusion only)?

Emergency Medications

ONC NURSING COMMUNICATION 35

Treatment of inFLIXimab or biosimilar infusion reactions

For mild reactions, the rate of infusion should be decreased to 10 mL/hour. Initiate a normal saline infusion (500 to 1,000 mL/hour) and appropriate symptomatic treatment (eg, acetaminophen and diphenhydramine); monitor vital signs every 10 minutes until normal. After 20 minutes, the infusion may be increased at 15-minute intervals, as tolerated, to completion (initial increase to 20 mL/hour, then 40 mL/hour, then 80 mL/hour, etc [maximum of 125 mL/hour]).

For moderate reactions, the infusion should be stopped or slowed. Initiate a normal saline infusion (500 to 1,000 mL/hour) and appropriate symptomatic treatment. Monitor vital signs every 5 minutes until normal. After 20 minutes, the infusion may be reinstated at 10 mL/hour; then increased at 15-minute intervals, as tolerated, to completion (initial increase 20 mL/hour, then 40 mL/hour, then 80 mL/hour, etc [maximum of 125 mL/hour]).

For severe reactions, the infusion should be stopped and CONTACT PROVIDER for appropriate symptomatic treatment orders (eg, hydrocortisone/methylprednisolone, diphenhydramine and epinephrine) and monitor frequent vitals. Call 911 if necessary.

sodium chloride 0.9% bolus injection 500 mL

500 mL, Intravenous, for 60 Minutes, Once PRN, Other, Symptomatic treatment of infusion reaction., Starting S, For 1 Doses

acetaminophen (TYLENOL) tablet 650 mg

650 mg, Oral, Once PRN, Other, Symptomatic treatment of infusion reaction, Starting S, For 1 Doses

diphenhydrAMINE (BENADRYL) capsule 25 mg

25 mg, Oral, Once PRN, Other, For symptomatic treatment of infusion reaction and able to take orally, Starting S, For 1 Doses

diphenhydrAMINE (BENADRYL) injection 50 mg

50 mg, Intravenous, Once PRN, Other, Symptomatic treatment of infusion reaction and unable to take orally., Starting S, For 1 Doses

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Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		VALIDATED:		ORDERED:		Pager #
TIME	DATE	TIME	DATE	TIME	DATE	
	Sign		R.N. Sign		Physician Print	Physician

EPIC VERSION DATE: 03-19-20