Spectrum Health Helen DeVos children's hospital

# Physician's Orders INFLIXIMAB (RENFLEXIS/ INFLECTRA/REMICADE - PEDIATRIC, OUTPATIENT, INFUSION CENTER



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 Day 70

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+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Labs and infusion

## Safety Parameters and Special Instructions

☑ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 6
Verify all INDUCTION/LOADING DOSES given prior to start of MAINTENANCE DOSES

## Provider Reminder

☑ 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!!**

☑ ONC PROVIDER REMINDER
Premedication is not required, but can be considered for the prevention of subsequent infusion reactions. For symptoms of allergic reaction or anaphylaxis, order "Peds Hypersensitivity Reactions Therapy Plan".

☑ ONC PROVIDER REMINDER 3
Prior to initial infliximab infusion and annually, all patients must have a TB test (Quantiferon Gold) completed.

## Pre-Medications

☐ **Acetaminophen Premed - select suspension, tablet or chewable.**

☐ acetaminophen (TYLENOL) 32 MG/ML suspension 15 mg/kg (Treatment Plan)
15 mg/kg, Oral, Once, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 1000mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000mg/day

**Confidentiality of this medical record** shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

***CONTINUED ON PAGE 2 ➔***

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

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## Pre-Medications (continued)

- ☐ acetaminophen (TYLENOL) tablet 15 mg/kg (Treatment Plan)
  15 mg/kg, Oral, Once, Starting S, For 1 Doses
  Give 30 to 60 minutes prior to infusion.
  Recommended maximum single dose is 1000mg
  No more than 5 doses from all sources in 24 hour period, not to exceed 4000mg/day
- ☐ acetaminophen (TYLENOL) dispersable / chewable tablet 15 mg/kg (Treatment Plan)
  15 mg/kg, Oral, Once, Starting S, For 1 Doses
  Give 30 to 60 minutes prior to infusion.
  Recommended maximum single dose is 1000mg
  No more than 5 doses from all sources in 24 hour period, not to exceed 4000mg/day

☐ **Diphenhydramine Premed - select capsule, liquid or injection.**

- ☐ diphenhydrAMINE (BENADRYL) capsule 1 mg/kg (Treatment Plan)
  1 mg/kg, Oral, Once, Starting S, For 1 Doses
  Give 30 to 60 minutes prior to infusion.
  Recommended maximum single dose is 50mg
- ☐ diphenhydrAMINE (BENADRYL) 12.5 MG/5ML elixir 1 mg/kg (Treatment Plan)
  1 mg/kg, Oral, Once, Starting S, For 1 Doses
  Give 30 to 60 minutes prior to infusion.
  Recommended maximum single dose is 50mg
- ☐ diphenhydrAMINE (BENADRYL) injection 1 mg/kg (Treatment Plan)
  1 mg/kg, Intravenous, Once, Starting S, For 1 Doses
  Give 30 to 60 minutes prior to infusion.
  Recommended maximum single dose is 50mg

- ☐ methylPREDNISolone sodium succinate (SOLU-Medrol) injection 0.5 mg/kg (Treatment Plan)
  0.5 mg/kg, Intravenous, for 15 Minutes, Once, For 1 Doses
  Administer 30 to 60 minutes prior to infusion.
  Recommended maximum single dose is 80mg

- ☐ Premedication with dose: ________________________________
- ☐ Premedication with dose:________________________________

## Medications

☑ **Select Either Infliximab-abda (renflexis)(preferred Formulary Product) Or Infliximab (remicade) Or Infliximab-dyyb (inflectra). Defer to insurance requirements for specific product covered. Proceed with administration based on coverage. If more than one is approved, will confirm with ordering provider.**

- ☐ inFLIXimab-abda (RENFLEXIS) IVPB
  Dose:
  - ☐ 3 mg/kg
  - ☐ 5 mg/kg
  - ☐ 10 mg/kg
  - ☐ ________

  Intravenous, Titrate, Starting S, For 1 Doses
  {Select weight based administration instructions for inFLIXimab or biosimilar:55076}

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## Medications (continued)

- ☐ inFLIXimab (REMICADE) IVPB
  Dose:
  - ☐ 3 mg/kg
  - ☐ 5 mg/kg
  - ☐ 10 mg/kg
  - ☐ ________

  Intravenous, Titrate, Starting S, For 1 Doses
  {Select weight based administration instructions for inFLIXimab or biosimilar:55076}

- ☐ inFLIXimab-dyyb (INFLECTRA) IVPB
  Dose:
  - ☐ 3 mg/kg
  - ☐ 5 mg/kg
  - ☐ 10 mg/kg
  - ☐ ________

  Intravenous, Titrate, Starting S, For 1 Doses
  {Select weight based administration instructions for inFLIXimab or biosimilar:55076}

## Nursing Orders

- ☑ ONC NURSING COMMUNICATION 1
  - Obtain height and weight at each visit.
  - Place Intermittent Infusion Device
  - Infuse through a 0.2 micron, low protein binding inline filter.
  - Do not administer if the solution is discolored or if foreign particulate matter is present.
  - Monitor vital signs with pulse oximetry, temperature, heart rate, respiratory rate, blood pressure and pulse oximetry and assess for symptoms of anaphylaxis every 15 minutes through 30 minutes after drug completion.
  - Notify attending physician, NP or PA-C and stop drug infusion immediately if patient has itching, hives, swelling, temperature greater than 101 degrees Fahrenheit, rigors, dyspnea, cough or bronchospasm. Notify if greater than 20% decrease in systolic or diastolic blood pressure.
  - At the end of infusion, flush secondary line with 0.9% Sodium Chloride.
  - Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.
- ☑ ONC NURSING COMMUNICATION 2
  Discharge patient to home after infusion if no signs/symptoms of reaction.

## Labs

| | Interval | Duration |
|---|---|---|
| ☐ Complete Blood Count w/Differential<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |
| ☐ Reticulocyte Count with Reticulocyte Hemoglobin<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |
| ☐ Comprehensive Metabolic Panel (CMP)<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |
| ☐ Hepatic Function Panel (Liver Panel)<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |
| ☐ Ferritin, Blood Level<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |

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# INFLIXIMAB (RENFLEXIS/ INFLECTRA/REMICADE - PEDIATRIC, OUTPATIENT, INFUSION CENTER *(CONTINUED)*



Patient Name

DOB

MRN

Physician

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| | | Interval | Duration |
|---|---|---|---|
| ☐ | Iron and Iron Binding Capacity Level<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |
| ☐ | Sedimentation rate<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |
| ☐ | C Reactive Protein (CRP), Blood Level<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |
| ☐ | Vitamin D 25 Hydroxy<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |
| ☐ | Thiopurine Metabolites<br>STAT, Starting S, For 1 Occurrences<br>Current Therapeutic Name:<br>Current Dose mg/day:<br>Blood, Venous | | |
| ☐ | Anser IFX<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | | |
| ☐ | TB Screen (Quantiferon Gold)<br>STAT, Starting S, For 1 Occurrences, Blood, Venous | Every 365 days | 1 treatment |
| | Other Labs: ______________________________________ | ☐ Every __days<br>☐ Once | ☐ Until date:_______<br>☐ 1 year<br>☐ ______# of Treatments |

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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:**<br>**TIME** **DATE** | **VALIDATED:**<br>**TIME** **DATE** | **ORDERED:**<br>**TIME** **DATE** | Pager # |
|---|---|---|---|
| **Sign** | **R.N. Sign** | **Physician Print** | **Physician** |

**EPIC VERSION DATE:** 07/26/20

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