Corewell Health™

Reset Form

PREFERRED CLINIC: --Select--

Physician's Orders – inFLIXimab, Adult

PATIENT INFORMATION

Name: Date of Birth: Phone:

Address: Height: (cm) Weight: (kg)

Anticipated Infusion Date: Allergies:

CLINICAL INFORMATION

Diagnosis code & description (required) ICD-10 Code: ICD-10 Description:

LABS

	Frequency/Duration		Frequency/Duration
☐ CBC w/Differential	_____	☐ Hepatitis B Surface Antigen	_____
☐ CMP	_____	☐ Hepatitis B Core Total Antibody	_____
☐ Quantiferon Gold	_____	☐ _____	_____

PRE-MEDICATIONS

☐ Acetaminophen PO ☐ 325 mg ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ MethylPREDNIsolone IV ☐ 40 mg ☐ 125 mg ☐ _____ mg

☐ DiphenhydrAMINE ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

MEDICATION – INFLIXIMAB IV

☐ **Preferred inFLIXimab biosimilar** - Corewell Health selects product (Guided by Corewell Health and patient's insurance formulary)

☐ **Dispense as written (DAW)** _____

Dose	Frequency	Duration
☐ 3 mg/kg ☐ 5 mg/kg ☐ 10 mg/kg ☐ _____ mg/kg ☐ _____ mg	☐ **Induction** Infuse at week 0, 2, and 6 ☐ **Maintenance** ☐ Every 6 weeks ☐ Every 8 weeks ☐ Every _____ weeks	☐ 1 Year ☐ # of treatments _____ ☐ Until date: _____

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

SUPPLEMENTAL ORDERS

☒ Premedication is not required but can be considered for the prevention of subsequent infusion reactions. Prior to initial 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)

☒ CAUTION - ENSURE APPROPRIATE TIMING BETWEEN INDUCTION AND MAINTENANCE PLANS. Usual Induction therapy is administered weeks 0, 2, and 6. The Corewell Health Therapy Plan for INDUCTION contains weeks 0 and 2. The MAINTENANCE plan starts WEEK 6 and continues every 8 weeks. Verify all INDUCTION DOSES given prior to start of MAINTENANCE DOSES

☒ In patients with moderate to severe heart failure, use of infliximab at doses of > 5 mg/kg is contraindicated. In patients who have experienced a severe hypersensitivity reaction to infliximab products, infliximab is contraindicated.

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

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

☒ Vital Signs - 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. If patient has an acute reaction with preceding dose, monitor vitals every 10 minutes for 30 min then every 30 minutes and for 30 minutes after infusion

☒ Notify physician of signs & symptoms of adverse reactions. If reaction occurs, call physician immediately. Patients receiving infliximab have increased risk for infections. Monitor for signs of infection.

☒ May Initiate IV Catheter Patency Adult Protocol

☒ Hypersensitivity Reaction Adult Oncology Protocol - RN may initiate treatment in the event of a drug related hypersensitivity reaction

☒ 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.

☒ May proceed with treatment if tuberculosis screening test with either QuantiFERON® Gold Plus or TB skin test have been resulted prior to first dose within one year for continuing therapy, and the results are negative.

RECOMMENDED DOCUMENTATION: ☐ Insurance Card / Information ☐ Progress Notes ☐ Hep B Surface Antigen ☐ TB status

PROVIDER INFORMATION

Referring Physician: Phone: Fax:

Address: City: State: Zip Code:

Direct line for urgent questions about patient: Weekend on call phone (if applicable):

_____ **Provider Signature**

_____ **Date**

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