Corewell Health™

Patient Name
DOB
MRN
Physician
CSN

Physician's Orders
INFLIXIMAB (RENFLEXIS/INFLECTRA/ REMICADE) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER
Page 1 to 6

Defaults for orders not otherwise specified below:

- ☐ Interval: **INDUCTION** – Every 14 days x 2 treatments (maintenance treatment starts on day 42)
- ☐ Interval: **MAINTENANCE** – Every 56 days

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

☐ CH Blodgett (GR)	☐ CH Helen DeVos (GR)	☐ CH Ludington	☐ CH Reed City
☐ CH Gerber	☐ CH Lemmen Holton (GR)	☐ CH Pennock	☐ CH Zeeland
☐ CH Greenville			

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

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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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Labs

	Interval	Duration
☑ Complete Blood Count w/Differential Status: Future, Expected: S, Expires: S+184, URGENT, Clinic Collect, Blood, Blood, Venous	☐ Once ☐ Every 56 days	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
☑ Basic Metabolic Panel (BMP) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	Once	1 treatment
☑ Hepatic Function Panel (Liver Panel) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	☐ Once ☐ Every 56 days	☐ Until date: _____ ☐ 1 year ☐ ____# of Treatments
☑ Hepatitis B Surface Antigen Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	☐ Once ☐ PRN	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
☑ Hepatitis B Core Total Antibody Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	☐ Once ☐ PRN	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
☑ Comprehensive Metabolic Panel (CMP) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	☐ Once ☐ Every 56 days	☐ 1 year ☐ _____# of Treatments

☑ **Arrange For Patient To Have Id Tb Skin Test Administered And Read Or Serum Tb Screening Lab Prior To Therapy Or Annually**

☐ 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
☐ TB Screen (Quantiferon Gold) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	Once	1 treatment

	Interval	Duration
☐ Labs: _____	☐ Every____days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments

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INFLIXIMAB (RENFLEXIS/INFLECTRA/ REMICADE) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

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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 (INFECTRA):

☑ ONC NURSING COMMUNICATION 100

May Initiate IV Catheter Patency Adult Protocol

☑ Hypersensitivity Reaction Adult Oncology Protocol — S — Until discont'd

Routine, Until discontinued Starting when released for 24 hours
HYPERSENSITIVITY REACTIONS:
Discontinue the medication infusion immediately.

Activate emergency response for severe or rapidly progressing symptoms. Where available consider calling RAP and have crash cart available. Call 911 or code team (if applicable) as needed for an absence of pulse and respirations. Refer to site specific emergency response policy.

Stay with patient until symptoms have resolved.

Initiate/Continue Oxygen to maintain SpO2 greater than 90% and discontinue Oxygen Therapy to maintain SpO2 above 90%

For severe or rapidly progressing hypersensitivity reaction symptoms, monitor vital signs and pulse oximeter readings every 2 to 5 minutes until the patient is stable and symptoms resolve.

Document medication infusing and approximate dose received at time of reaction in the patient medical record. Document allergy to medication attributed with causing reaction in patient medical record. Complete Adverse Drug Reaction form per Pharmacy Clinical Policy.

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.

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Pre-Medications

☐ acetaminophen (TYLENOL) tablet 650 mg
650 mg, Oral, Once, Starting S, For 1 Doses

☐ diphenhydrAMINE (BENADRYL) capsule
Dose:
- ☐ 25 mg
- ☐ 50 mg

Oral, Once, Starting S, For 1 Doses

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

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

Additional Pre-Medications

☐ Pre-medication with dose: _____

☐ Pre-medication with dose:

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INFLIXIMAB (RENFLEXIS/INFLECTRA/ REMICADE) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

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Induction Treatment

☑ **Select Either Infliximab-abda (Renflexis) Or Infliximab-dyyb (Inflectra) Or Infliximab (Remicade)**

☐ inFLIXimab-abda (RENFLEXIS) IVPB (**PREFFERED FORMULARY PRODUCT**)

Dose:

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

Intravenous, Administer over 2 Hours, Once, Starting S+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.

☐ inFLIXimab-dyyb (INFLECTRA) IVPB

Dose:

- ☐ 3 mg/kg
- ☐ 5 mg/kg
- ☐ 10 mg/kg
- ☐_☐_ mg/kg

Intravenous, Administer over 2 Hours, Once, Starting S+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.

☐ inFLIXimab (REMICADE) IVPB

Dose:

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

Intravenous, Administer over 2 Hours, Once, Starting S+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.

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INFLIXIMAB (RENFLEXIS/INFLECTRA/ REMICADE) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

Maintenance Treatment

☑ **Select Either Infliximab-abda (Renflexis) Or Infliximab-dyyb (Inflectra) Or Infliximab (Remicade)**

☐ inFLIXimab-abda (RENFLEXIS) IVPB (**PREFFERED FORMULARY PRODUCT**)

Dose:
- ☐ 3 mg/kg
- ☐ 5 mg/kg
- ☐ 10 mg/kg
- ☐ ____mg/kg

Intravenous, Administer over 2 Hours, Once, Starting S+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.

☐ inFLIXimab-dyyb (INFLECTRA) IVPB

Dose:
- ☐ 3 mg/kg
- ☐ 5 mg/kg
- ☐ 10 mg/kg
- ☐ _____ mg/kg

Intravenous, Administer over 2 Hours, Once, Starting S+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.

☐ inFLIXimab (REMICADE) IVPB

Dose:
- ☐ 3 mg/kg
- ☐ 5 mg/kg
- ☐ 10 mg/kg
- ☐ ____mg/kg
- ☐

Intravenous, Administer over 2 Hours, Once, Starting S+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.

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:**			
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #	
	Sign		**R.N. Sign**		**Physician Print**		**Physician Sign**

EPIC VERSION DATE: 12-14-23

