

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

Patient Name
DOB
MRN
Physician
CSN

Page 1 of 4

Defaults for orders not otherwise specified below: Interval: INDUCTION – Every 14 days x 2 treatments (maintenance treatment to starts on day 42)					
□ Interval: MAINTENANCE – Every 56 days					
Duration:					
□ Until date: □ 1 year					
□ 1 year □# of T	reatments				
Anticipated Infusion [DateICD 10 Code with [Description			
Height	_(cm) Weight(kg) Allergi	es			
Site of Service					
☐ SH Gerber	☐ SH Lemmen Holton (GR)	□ SH Pennock	☐ SH United Memorial		
☐ SH Helen DeVos (G	GR) □ SH Ludington	□ SH Reed City	□ SH Zeeland		
Provider Specialty	Diefortions Discoss		□ Dhaumatala m		
☐ Cardiology	y Infectious Disease	□ OB/GYN □ Other	☐ Rheumatology		
☐ Gastroenterology		☐ Otolaryngology	□ Surgery □ Urology		
☐ Gastroenterology	☐ Neurology	☐ Pulmonary	☐ Wound Care		
- Octicuos	- Neurology		- Would Gale		
Appointment Reque	ests				
Appointmont Roque					
✓ Infusion A	Appointment Request				
Status: Fu Labs and i	ture, Expected: S, Expires: S+365, Sched. Tolerar nfusion	nce: Schedule appointment at m	nost 3 days before or at most 3 days after,		
Safety Parameters a	and Special Instructions				
✓ ONC SAF	FETY PARAMETERS AND SPECIAL IN	STRUCTIONS 6			
Verify all II	NDUCTION/LOADING DOSES given prior to start	of MAINTENANCE DOSES			
Provider Reminder					
✓ ONC PRO	OVIDER 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 PRO	OVIDER 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 PRO	OVIDER REMINDER 3				
Prior to init	Prior to initial infliximah infusion and annually, all natients must have a TR test (Quantiferon Gold) completed				

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Pre-N	/ledic	ations
	Π Δc	etamir

	Ace	taminophen Premed - select suspension, tablet or chewable.
		acetaminophen (TYLENOL) 32 MG/ML suspension 15 mg/kg
		15 mg/kg, Oral, Once, For 1 Dose
		Give 30 to 60 minutes prior to infusion.
		Recommended maximum single dose is 1000 mg. No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day.
		acetaminophen (TYLENOL) tablet 15 mg/kg
	ш	15 mg/kg, Oral, Once, Starting S, For 1 Dose
		Give 30 to 60 minutes prior to infusion.
		Recommended maximum single dose is 1000 mg.
		No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day.
		acetaminophen (TYLENOL) dispersable / chewable tablet 15 mg/kg
		15 mg/kg, Oral, Once, Starting S, For 1 Dose
		Give 30 to 60 minutes prior to infusion.
		Recommended maximum single dose is 1000 mg. No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day.
		The more than a doce from all sources in 24 hour period, not to exceed 4000 highway.
	Dip	ohenhydramine Premed - select capsule, liquid or injection
		diphenhydrAMINE (BENADRYL) capsule 1 mg/kg
	_	1 mg/kg, Oral, Once, Starting S, For 1 Dose
		Give 30 to 60 minutes prior to infusion.
		Recommended maximum single dose is 50 mg.
		diphenhydrAMINE (BENADRYL) 12.5 MG/5ML elixir 1 mg/kg
		1 mg/kg, Oral, Once, Starting S, For 1 Dose
		Give 30 to 60 minutes prior to infusion.
	_	Recommended maximum single dose is 50 mg.
		diphenhydrAMINE (BENADRYL) injection 1 mg/kg
		1 mg/kg, Intravenous, Once, Starting S, For 1 Dose
		Give 30 to 60 minutes prior to infusion. Recommended maximum single dose is 50 mg.
		, to commonate maximum single accorded to mg.
П	me	thyIPREDNISolone sodium succinate (SOLU-Medrol) injection 0.5 mg/kg
ш		.5 mg/kg, Intravenous, for 15 Minutes, Once, For 1 Dose
		dminister 30 to 60 minutes prior to infusion.
		lecommended maximum single dose is 80 mg.
itio	nal l	Pre-Medications
	Pre-	medication with dose:
	Pre-	medication with dose:
		modification with door.

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.



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Page 3 of 4

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Medications

Inf	lect Either Infliximab-abda (Renflexis) (PREFERRED Formulary Product) Or Infliximab (Remicade) Or liximab-dyyb (Inflectra). Defer to insurance requirements for specific product covered. Proceed with ministration 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 □ mg/kg
	□IIIg/kg
	Intravenous, Titrate, Starting S, For 1 Dose
	Pharmacist to select weight-based administration instructions for inFLIXimab or biosimilar in Admin. Inst. field.
	inFLIXimab (REMICADE) IVPB Dose:
	□ 3 mg/kg
	□ 5 mg/kg
	□ 10 mg/kg
	□ mg/kg
	Intravenous, Titrate, Starting S, For 1 Dose
	Pharmacist to select weight-based administration instructions for inFLIXimab or biosimilar in <i>Admin. Inst.</i> field.
	inFLIXimab-dyyb (INFLECTRA) IVPB
	Dose:
	□ 3 mg/kg
	□ 5 mg/kg
	□ 10 mg/kg □ mg/kg
	mg/kg
	Intravenous, Titrate, Starting S, For 1 Dose
	Pharmacist to select weight-based administration instructions for inFLIXimab or biosimilar in Admin. Inst. field.
Nursing C	orders
	ONO NIUDOINO COMMUNICATION A
~	ONC NURSING COMMUNICATION 1 - Obtain height and weight at each visit.
	- Obtain neight 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.

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Page	4	of	4
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P	atient Name
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Labs				
			Interval	Duration
		Complete Blood Count w/Differential		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		Reticulocyte Count with Reticulocyte Hemoglobin		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		Comprehensive Metabolic Panel (CMP)		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		Hepatic Function Panel (Liver Panel)		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		Ferritin, Blood Level		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		Iron and Iron Binding Capacity Level		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		Sedimentation rate		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		C Reactive Protein (CRP), Blood Level		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		Vitamin D 25 Hydroxy		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		Thiopurine Metabolites		
		STAT, Starting S, For 1 Occurrence		
		Current Therapeutic Name:		
		Current Dose mg/day:		
		Blood, Venous		
		Anser IFX		
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
		TB Screen (Quantiferon Gold)	Every 365 days	1 treatment
		STAT, Starting S, For 1 Occurrence, Blood, Venous		
Additi	ional	Lab Orders		
			Interval	Duration
	□ Lab:		□ Everydays	□ Until date:
			□ Once	□ 1 year
				□# of Treatments
	□ Lab:		□ Everydays	□ Until date:
			□ Once	□ 1 year
				□# of Treatments

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:		
TI	ME DATE	TIME DATE		TIME	DATE	Pager #
	Sign		R.N. Sign		Physician Print	Physician

EPIC VERSION DATE: 07/26/20