

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

Page 1 of 4

Patient Name
 DOB
 MRN
 Physician
 CSN

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
- ☐ _____ # of Treatments

Anticipated Infusion Date _____ ICD 10 Code with Description _____

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

Site of Service

- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> SH Gerber | <input type="checkbox"/> SH Lemmen Holton (GR) | <input type="checkbox"/> SH Pennock | <input type="checkbox"/> SH United Memorial |
| <input type="checkbox"/> SH Helen DeVos (GR) | <input type="checkbox"/> SH Ludington | <input type="checkbox"/> SH Reed City | <input type="checkbox"/> SH Zeeland |

Provider Specialty

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal Med/Family Practice | <input type="checkbox"/> Other | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Neurology | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Wound Care |

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, 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.

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

Pre-Medications

☐ **Acetaminophen 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
 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.

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

Additional Pre-Medications

☐ Pre-medication with dose:

☐ Pre-medication 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
☐ _____ mg/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 *Admin. Inst.* field.

- ☐ inFLIXimab-dyyb (INFLECTRA) 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 *Admin. Inst.* field.

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.

