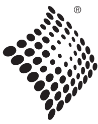


Spectrum Health

Physician's Orders INFLIXIMAB (RENFLEXIS/ INFLECTRA/REMICADE) - ADULT, OUTPATIENT, INFUSION CENTER

Patient Name

DOB

MRN

Physician

FIN

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

☐ 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+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

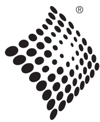
TUBERCULOSIS SURVEILLANCE AND MANAGEMENT RECOMMENDATIONS: Screen prior to treatment and annually for continuing therapy. Treat latent infection prior to starting therapy.

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.

 © Spectrum Health



Spectrum Health

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

Page 2 to 6

Patient Name

DOB

MRN

Physician

FIN

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	☐ Until date: _______ ☐ 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**

		Interval	Duration
☐	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

Additional Lab Orders

		Interval	Duration
☐	Labs: ____	☐ Every ___days ☐ Once	☐ Until date: _______ ☐ 1 year ☐ ______# of Treatments

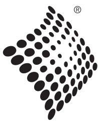
Vitals

☑ 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.

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 3 ➔



Spectrum Health

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

Page 3 to 6

Patient Name

DOB

MRN

Physician

FIN

Nursing Orders

☑ ONC NURSING COMMUNICATION 1

INFLIXIMAB-ABDA (RENFLEXIS) OR INFLIXIMAB (REMICADE) OR INFLIXIMAB-DYYB (INFECTRA):

Notify physician of signs and symptoms of adverse reactions. If reaction occurs, call physician immediately.

Patients receiving infliximab or biosimilars are at increased risk for serious infections. Monitor for signs of infection.

☑ ONC NURSING COMMUNICATION 100

May Initiate IV Catheter Patency Adult Protocol

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.

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

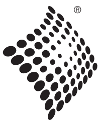
Additional Pre-Medications

☐ Pre-medication with dose: ____

☐ Pre-medication with dose: ____

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 4 ➔



Patient Name

DOB

MRN

Physician

FIN

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

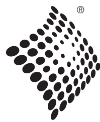
Intravenous, Administer over 2 Hours, Once, Starting S+30 Minutes, For 1 Doses

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.

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 5 ➔



Spectrum Health

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

Patient Name
DOB
MRN
Physician
FIN

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.

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.

Patient Name

DOB

MRN

Physician

FIN

Emergency Medications

☑ ONC NURSING COMMUNICATION 35

Treatment of inFLIXimab or biosimilar infusion reactions

For mild reactions, the rate of infusion should be decreased to 10 mL/hour. Initiate a normal saline infusion (500 to 1,000 mL/hour) and appropriate symptomatic treatment (eg, acetaminophen and diphenhydramine); monitor vital signs every 10 minutes until normal. After 20 minutes, the infusion may be increased at 15-minute intervals, as tolerated, to completion (initial increase to 20 mL/hour, then 40 mL/hour, then 80 mL/hour, etc [maximum of 125 mL/hour]).

For moderate reactions, the infusion should be stopped or slowed. Initiate a normal saline infusion (500 to 1,000 mL/hour) and appropriate symptomatic treatment. Monitor vital signs every 5 minutes until normal. After 20 minutes, the infusion may be reinstituted at 10 mL/hour; then increased at 15-minute intervals, as tolerated, to completion (initial increase 20 mL/hour, then 40 mL/hour, then 80 mL/hour, etc [maximum of 125 mL/hour]).

For severe reactions, the infusion should be stopped and CONTACT PROVIDER for appropriate symptomatic treatment orders (eg, hydrocortisone/methylprednisolone, diphenhydramine and epinephrine) and monitor frequent vitals. Call 911 if necessary.

☑ sodium chloride 0.9% bolus injection 500 mL

500 mL, Intravenous, Administer over 60 Minutes, Once PRN, Other, Symptomatic treatment of infusion reaction., Starting S, For 1 Doses

☑ acetaminophen (TYLENOL) tablet 650 mg

650 mg, Oral, Once PRN, Other, Symptomatic treatment of infusion reaction, Starting S, For 1 Doses

☑ diphenhydrAMINE (BENADRYL) capsule 25 mg

25 mg, Oral, Once PRN, Other, For symptomatic treatment of infusion reaction and able to take orally, Starting S, For 1 Doses

☑ diphenhydrAMINE (BENADRYL) injection 50 mg

50 mg, Intravenous, Once PRN, Other, Symptomatic treatment of infusion reaction and unable to take orally., Starting S, For 1 Doses

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.

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: TIME DATE	VALIDATED: TIME DATE	ORDERED: TIME DATE	Pager #
Sign	R.N. Sign	Physician Print	Physician

EPIC VERSION DATE: 03-19-20