St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Infliximab or biosimilar	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. Patients should not have an active ongoing infection, signs or symptoms of malignancy, or moderate to severe heart failure at the onset of TNF-alpha inhibitor therapy. Baseline liver function tests should be normal.
5. Patient should have regular monitoring for TB, hepatitis B, infection, malignancy, and liver abnormalities throughout therapy.
6. Patients being considered for treatment with infliximab should not have an active ongoing infection. Patients treated with infliximab products are at increased risk for developing serious infections. Monitor for signs and symptoms of infection during and after treatment with infliximab.

PRE-SCREENING: (Results must be available prior to initiation of therapy):
☐ Hepatitis B surface antigen and core antibody test results scanned with orders.
☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:
☐ Complete Metabolic Panel, Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**
☐ CBC with auto differential, Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**

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NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. TREAMENT PARAMETER – Hold infusion and contact provider if patient has signs or symptoms of infection.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
4. Infuse over 2 hours for first 4 infusions. If tolerated first 4 infusions well (no grade 3 or 4 infusion reactions), may infuse rapidly at 250 mL/hr over 1 hour.
5. For previous infusion reactions, begin all subsequent infusions at 10 mL/hr for 15 minutes, then double the rate every 15 minutes up to a maximum of 125 mL/hr. If tolerated infusion well without need of premeds, discuss with a provider to change infusion rate case by case.
6. Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion, then every 15 minutes x 30 minutes, then every 30 minutes until infusion is completed. Consider observing patient for 60-minute following infusion.

PREMEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit

☐ diphenhydrAMINE (BENADRYL) injection, 25 mg, oral, ONCE, every visit. **Give either cetirizine or diphenhydrAMINE, not both.**

☐ cetirizine (ZYRTEC) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. **Give either cetirizine or diphenhydrAMINE, not both.**

☐ methylPREDNISolone sodium succinate (SOLU-MEDROL), 40 mg, intravenous, ONCE AS NEEDED if patient has required IV steroids for a reaction during a prior TNF-alpha inhibitor infusion, every visit

MEDICATIONS:

Biosimilar selection (must check one) – applies to all orders below, products listed in preference to St. Charles

☐ REMICADE (inFLIXimab) (St. Charles preferred brand)
☐ INFLIXIMAB (Generic Remicade)
☐ RENFLEXIS (inFLIXimab-abda)
☐ AVSOLA (inFLIXimab-axxq)
☐ INFLECTRA (inFLIXimab-dyyb)
☐ _____

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At St. Charles, if insurance requires a different biosimilar agent, pharmacy will update the order per CDTM.

☐ Only check this box if it is NOT okay to substitute for insurance. Dispense as written (DAW).

Infliximab will be dosed off the most recent weight and rounded to the nearest 100 mg increment unless the provider specifies otherwise.

☐ No dose rounding (Reason for medical necessity): _____

(Select a dosing regimen)

Select	
☐	3 mg/kg IV at 0, 2, and 6 weeks followed by 3 mg/kg every 8 weeks thereafter
☐	5 mg/kg IV at 0, 2, and 6 weeks followed by 5 mg/kg every 6 weeks thereafter
☐	5 mg/kg IV at 0, 2, and 6 weeks followed by 5 mg/kg every 8 weeks thereafter
☐	10 mg/kg IV every ____ weeks
☐	____ mg/kg IV every _____ weeks
☐	Other, please specify: _____

AS NEEDED MEDICATIONS:

1. sodium chloride 0.9% solution, intravenous, 500 mL, AS NEEDED x1 dose, for TNF-alpha inhibitor infusion tolerability. Give concurrently with TNF-alpha inhibitor

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

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Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed