

Columbus Community Hospital

Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here

**PHYSICIANS ORDERS
(including Medications)**

InFLIXimab Infusion

(8/2024)

Page 1 of 3

Diagnosis Code: _____

Treatment Start Date: _____ Patient to follow up with provider on date: _____

****This plan will expire after 365 days at which time a new order will need to be placed****

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:

- CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- Labs already drawn. Date: _____

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. TREATMENT PARAMETER – Hold infusion and contact provider if patient has signs or symptoms of infection.
3. Utilize administration set with in line filter 1.2 microns or less.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, de clotting (alteplase), and/or dressing changes.
5. Infuse over 2 hours. 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.
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. Observe patient for 60-minute following first 2 infusions or if had previous reaction to InFLIXimab.

(cont.)



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PRE-MEDICATIONS: (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) capsule, 50 mg, oral, ONCE, every visit.
- loratadine (CLARITIN) tablet, 10 mg, oral, ONCE every visit.
- 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
- Other _____

MEDICATIONS:

Biosimilar selection (must check one) – applies to all orders below

- RENFLEXIS (inFLIXimab-abda) (CCH preferred)
- INFLECTRA (inFLIXimab-dyyb)
- REMICADE (inFLIXimab) Restricted to existing REMICADE patients for continuing therapy
- AVSOLA (inFLIXimab-axxq)
- _____

At CCH, if insurance requires a different biosimilar agent, pharmacy will update the order.

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

Initial Doses: (Pharmacist will use most recent weight and round dose up to use the entire 100 mg vial)

- 3 mg/kg in sodium chloride 0.9%, intravenous
- 5 mg/kg in sodium chloride 0.9%, intravenous

Interval: (must check one)

- Once
- Three doses at 0, 2, and 6 weeks; dates: Week 0 _____, Week 2 _____, Week 6 _____
- Other: _____

Maintenance Doses: (Pharmacist will use most recent weight and round dose up to use the entire 100 mg vial)

- 3 mg/kg in sodium chloride 0.9%, intravenous
- 5 mg/kg in sodium chloride 0.9%, intravenous

Interval:

- Every _____ weeks for _____ doses
- May infuse over one hour (must have tolerated 2-hour infusions four times prior)

(cont.)

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AS NEEDED MEDICATIONS:

1. Acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for hypersensitivity or infusion reaction, chills, or malaise.
2. DiphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching
3. Sodium chloride 0.9% solution, intravenous, 500 mL, AS NEEDED x1 dose, for TNF-alpha inhibitor infusion tolerability. Give concurrently with TNF-alpha inhibitor.

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION.**
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen, 975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

My NPI number is _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____	Date/Time: _____
Printed Name: _____	Phone: _____ Fax: _____