**GUIDELINES FOR ORDERING**

1. Send FACE SHEET and H&P or most recent chart note.
2. A Tuberculin test must have been placed and read as negative within the past year (PPD or QuantiFERON Gold blood test).
3. Hepatitis B (Hep B surface antigen and core antibody) screening must be completed prior to initiation of therapy and the patient should not be infected.
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.

**OTHER:**
- □ Tuberculin (TUBERSOL, APLISOL) injection, 5 units, intradermal, ONCE, Perform prior to initiation of TNF-alpha inhibitor therapy

**PRE-SCREENING:** (Results must be available prior to initiation of therapy):
- □ Hepatitis B Surface AG, serum, Routine, ONCE
- □ Hepatitis B Core AB Qual, serum, Routine, ONCE

OR
- □ Hepatitis B surface antigen and core antibody test results scanned with orders
  - Tuberculin Test Result. Date: ________ □ Positive / □ Negative

**LABS:**
- □ Antinuclear antibody screening, Routine, ONCE, prior to initiation of TNF-alpha inhibitor therapy
- □ Basic Metabolic Set, Routine, ONCE, every _______ (visit)(days)(weeks)(months) – Circle One
- □ CBC with differential, Routine, ONCE, every _______ (visit)(days)(weeks)(months) – Circle One
- □ Liver Set (AST, ALT, BILI TOTAL, BILI DIRECT, ALK PHOS, ALB, PROT TOTAL), Routine, ONCE, every _______ (visit)(days)(weeks)(months) – Circle One
- □ HCG Beta, PLASMA, routine, ONCE, every _______ (visit)(days)(weeks)(months) – Circle One
- □ Labs already drawn. Date: ________

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

Weight: _________ kg    Height: _________ cm
Allergies: ________________________________
Diagnosis Code: ________________________________
Treatment Start Date: _________  Patient to follow up with provider on date: ____________

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.
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, oral, ONCE, every visit
  - 325 mg
  - 650 mg
  - 500 mg
  - 1000 mg
- diphenhydramine (BENADRYL) capsule, oral, ONCE, every visit
  - 25 mg
  - 50 mg
- loratadine (CLARITIN) tablet, oral, ONCE, every visit
  (Choose as alternative to diphenhydramine if needed)
  - 5 mg
  - 10 mg
- methylprednisolone sodium succinate (SOLU-MEDROL), 40 mg, intravenous, ONCE, every visit
  (Choose if patient has required IV steroids for a reaction during a prior TNF-alpha inhibitor infusion)

MEDICATIONS:

Biosimilar selection (must check one) – applies to all orders below
- INFLECTRA (inFLIXimab-dyyb) **formulary agent**
- * REMICADE (inFLIXimab) Restricted to existing REMICADE patients for continuing therapy ONLY

Initial Doses: (Pharmacist will use most recent weight and round dose to the nearest 100 mg vial)
- 3 mg/kg in NaCl 0.9%, intravenous
- 5 mg/kg in NaCl 0.9%, intravenous
- 10 mg/kg in NaCl 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 to nearest 100 mg vial)
- 3 mg/kg in NaCl 0.9%, intravenous
- 5 mg/kg in NaCl 0.9%, intravenous
- 10 mg/kg in NaCl 0.9%, intravenous
Interval:
- Every _______ weeks for _____ doses
ADULT AMBULATORY INFUSION ORDER

inFLIXimab (INFLECTRA, REMICADE*)

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

NURSING ORDERS:
1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Infuse over at least 2 hours. Begin infusion at 10 mL/hr for 15 minutes, then double rate every 15 minutes during first hour. After 1 hour may increase to 250 mL/hr.
3. 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.

HYPERSENSITIVITY MEDICATIONS:
1. If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25 mg, intravenous, AS NEEDED x2 doses for hypersensitivity reaction, Max dose 50 mg
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

AS NEEDED MEDICATIONS:
1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever
2. diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching
3. sodium chloride 0.9% solution, intravenous, 500mL, AS NEEDED x1 dose, for TNF-alpha inhibitor infusion tolerability. Give concurrently with TNF-alpha inhibitor

By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: □ Oregon □ ____________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);
My physician license 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: ______________
Infusion orders located at: [www.ohsuknight.com/infusionorders](http://www.ohsuknight.com/infusionorders)