Infusion

Infliximab

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Date: _____ Is the patient in a SNF? ☐ Yes ☐ No Allergies: _____

Physician: _____ Phone: _____

NPI: _____ Tax ID: _____

ICD-10 Code **AND** description: _____

ORDERS PRECEDED BY A ■ REQUIRE A ☒ TO INITIATE THE ORDER.

Pt ht _____ Pt weight _____ (kg) _____Patient is stable with infusion and can be seen under general supervision

Choose one ☐Infliximab (Remicade) **OR** ☐Inflximab-dyyb (Inflectra) _____ mg/kg *(round dose up to the nearest 100mg)*.

Administer in 250-500ml NS with 1.2 micron or less filter. Infuse per facility protocol. **(A dose change will require a new order and insurance authorization)**

FREQUENCY: *(select one)*

☐ Initial dose, 2 weeks, 6 weeks, then every 8 weeks **OR** ☐ One dose only **OR** ☐ Other *(specify)* _____

PRE-MEDS (DRUG, DOSE, AND ROUTE):

Patients should be instructed to take oral medications ½ hr before appointment

☐**NO** pre-meds ☐Diphenhydramine *(check one)* ☐12.5mg IV ☐25mg IV ☐50mg IV If patient did not take oral meds at home

☐ Tylenol *(check one)* ☐500mg **OR** ☐650mg **OR** _____mg PO if patient did not take oral meds at home

☐ Ondansetron 4mg IV PRN Nausea ☐ Other *(drug, dose, route and frequency)* _____

FREQUENCY OF PRE-MED

☐Prior to each dose of Infliximab

LABORATORY TESTING:

☒QFG TB testing every 12 months while on therapy. Most current TB test & type: _____ Results: _____

☐ Lab with each infusion _____

☐ **CMP** ☐ **CBC** ☐ **ESR** ☐ **CRP** ☐ **Folate** ☐ **Vit B-12** ☐ Other: _____

PATIENTS WITH CENTRAL LINE ACCESS:

Select one: ☐ Patient has a PICC ☐ Implanted port ☐ Other CVAD _____ ☐ Patient does not have a CVAD

☒ Central line care per Salem Health CVAD Access Policy and Lippincott procedure. Access/deaccess per manutacture device maintenance card if available.

☒ May use heparin flush solution per Salem Health CVAD/Lippincott procedures for devices requiring heparin.

☒ Alteplase per Salem Health Central Venous Access Device declotting *(Lippincott)* for S/sx of occlusion: Inability to infuse fluids, no blood return, increased resistance when flushing, increased occlusion/high-pressure alarm when using an infusion pump, sluggish gravity flow.

☒ 1 View Chest X-ray to verify PICC tip location PRN for: Catheter migration greater than 5 cm, signs and symptoms of tip malposition *(occlusion unresolved by Alteplase, discomfort in the arm, neck or chest, unusual sensations or sounds when flushing, neck vein engorgement, or heart palpitations.)* Notify Provider

Other Orders:

☒ Contact provider prior to infusion if patient reports changes from previous infusion related to: active infection, illness *(with or without fever)* active cancer, CHF, previous infusion reactions to Infliximab. Notify provider of all infusion reactions.

☒ Notify provider if infusion NOT given or patient status is 'No Show' for his or her appointment.

☒ Follow SH Infusion reaction protocol for symptom of infusion reaction.

Provider Signature _____ Provider Printed Name _____ Date: _____