

**PATIENT IDENTIFICATION**  
Known allergies / medication sensitivities:

☐ NL Infusion Care, AR Gould, **Presque Isle**  
Phone: 207-768-4589; Fax: 207-768-4183

☐ NL Infusion Care, **Blue Hill**  
Phone: 207-374-3995; Fax: 207-374-3970

☐ NL Infusion Care, CA Dean, **Greenville**  
Phone: 207-695-5222; Fax: 207-695-4801

☐ NL Infusion Care, **Brewer**  
Phone: 207-973-9785; Fax: 207-973-9788

☐ NL Infusion Care, **Waterville**  
Phone: 207-861-3380; Fax: 207-861-3348

☐ NL Mary Dow Center, **Ellsworth**  
Phone: 207-664-5584; Fax: 207-664-5485

☐ NL Infusion Care, Mayo, **Dover-Foxcroft**  
Phone: 207-564-4254; Fax: 207-564-4418

☐ NL Mercy Cancer Care, **Portland**  
Phone: 207-553-6868; Fax: 207-904-0917

☐ NL Infusion Care, SVH, **Pittsfield**  
Phone: 207-487-4052; Fax: 207-487-3995

**OUTPATIENT INFlixIMAB ORDERS - ADULT**

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**Diagnosis:** ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Plaque Psoriasis  
☐ Crohn's Disease ☐ Ulcerative Colitis

**ICD10:** \_\_\_\_\_

**Verification of T SPOT/PPD or Quantiferon:** TB testing is required prior to initiation of therapy, a change in living environment, or travel to an area that would pose an increased risk of TB. Please indicate date and result of test done:

T SPOT: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_

Quantiferon TB Gold Test: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_

PPD: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_

**Hepatitis B and C Testing:**

Hepatitis B: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_

Hepatitis C: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_

**IV Access:**

☐ Saline Lock:

☒ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*

☒ Discontinue Saline Lock after therapy completed

☐ PICC Line:

☒ Routine PICC Line Care, labs and restoration (Refer to Policy #26.802 & #26.807)

☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)

☐ Porta cath / Central Access Device (Hickman, Triple lumen):

☒ Porta cath access, labs, restoration and de-access (Refer to Policy #26.902) / Central Access Device use and care (Refer to Policy #26.102)

**Height:** \_\_\_\_\_ cm **Weight:** \_\_\_\_\_ kg

**Premedication:**

☒ Acetaminophen (Tylenol) 650 mg, PO, ONCE

☒ Cetirizine (Zyrtec) 10 mg, PO, ONCE

**Patient with risk of or confirmed previous adverse reactions:**

☐ Famotidine (Pepcid) 20 mg, PO, ONCE

☐ Hydrocortisone Sodium Succinate (Solu-Cortef) 100 mg, IVP, ONCE

**Medication:**

☐ Wait for lab results before infusing Infliximab

☒ Infliximab \_\_\_\_\_ mg/kg = \_\_\_\_\_ mg\* in 250 mL 0.9% Sodium Chloride, IVPB, via a non-protein binding filter (1.2 micron or less);  
Infuse at 80 mL/hour X 30 minutes (volume 40 mL), then 150 mL/hour X 30 minutes (volume 75 mL), then remainder of infusion over 1 hour.  
Total infusion no less than 2 hours x first 3 infusions; Infuse fourth infusion over 90 minutes; Infuse fifth and successive infusions over 60 minutes.

For patients that experience a reaction, they must remain on titratable rate noted above and are not eligible for the faster infusion rate.

(\*Rounded by pharmacy to nearest 100 mg for patients greater than 60 kg; otherwise rounded to the nearest 10 mg)

**Treatment Schedule:**

☐ One time dose

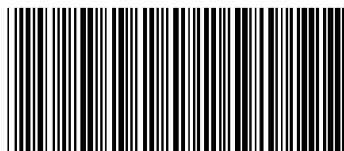
Initial Therapy: ☐ Weeks 0, 2 and 6 then ☐ Every 8 weeks or ☐ Every \_\_\_\_\_ weeks

Duration: ☐ 6 months

Maintenance: ☐ Every 8 weeks or ☐ Every \_\_\_\_\_ weeks

☐ 1 year

**Renflexis biosimilar is standard/preferred.**



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Date: \_\_\_\_\_ Time: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Pharmacy Signature: \_\_\_\_\_

**PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS**  
June 2024 (updated AR Gould #s)