PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

Northern Light Health

- ☐ 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

Diagnosis: ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylosis ☐ 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
Maintenance: ☐ Every 8 weeks or ☐ Every _____ weeks
Duration: ☐ 6 months ☐ 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)