

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

- ☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4151; Fax: 207-768-4022
- ☐ 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 Pediatric Oncology, **Brewer**
Phone: 207-973-7572; Fax: 207-973-9741
- ☐ NL Pediatric Sedation, EMMC, **Bangor**
Phone: 207-973-8758; Fax: 207-973-9583

- ☐ 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 –
PEDIATRIC**

Page 1 of 2

Height: _____ cm Weight: _____ kg

Diagnosis: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other: _____ **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 Testing: Hepatitis B: Date: ____/____/____ Result: _____

IV Access:

- ☒ Lidocaine 4% topical cream 1 APP, Cream, TOPICAL, PRN, PRN, Other(comment), NOT recommended for patient less than 1 month of age
- ☐ Saline Lock: ☒ Insert peripheral Saline Lock per protocol; may leave in for consecutive treatment days
☒ Discontinue Saline Lock after therapy completed
- ☐ PICC Line: ☒ Routine PICC Line Care, labs and restoration
☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)
- ☐ Porta cath / Central Access Device (Hickman, Triple lumen): Porta cath/Central Access Device access, labs, restoration and de-access

Diet:

☐ Diet (Specify type): _____

Laboratory:

**** Note:** DO NOT HOLD infusion for labs

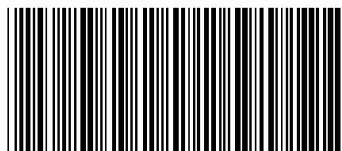
- ☐ CBC with differential ☐ Erythrocyte Sedimentation Rate **Frequency:** ☐ Prior to each infusion
- ☐ Comprehensive Metabolic Panel ☐ C-Reactive Protein ☐ Other: _____
- ☐ Infliximab Activity and Neutralizing Ab ☐ Other: _____

Premedication: to be given 30 minutes prior to infliximab (Remicade)

- ☐ acetaminophen (Tylenol) 15 mg/kg = _____ mg, Tablet, PO, ONCE, **Max dose 1000 mg**, May change to liquid if requested
- ☐ diphenhydramine (Benadryl) 1.25 mg/kg = _____ mg, Cap, PO, ONCE, **Max dose 50 mg**, May change to liquid if requested
- ☐ cetirizine (Zyrtec) 2.5 mg, Liquid, PO, ONCE, 5 years old and less
- ☐ cetirizine (Zyrtec) 5 mg, Liquid, PO, ONCE, 6 – 10 years old
- ☐ cetirizine (Zyrtec) 10 mg, Tab, PO, ONCE, Greater than 10 years old; May change to liquid if requested
- ☐ No pre-meds
- ☐ Continue previous pre medications. Pharmacy to check off pre medications above.

Patient with risk of or confirmed previous adverse reactions:

- ☐ famotidine (Pepcid) 0.5 mg/kg = _____ mg, Soln, IVPB, ONCE, **Max dose 20 mg**, May give PO (Tab or Susp) if requested
- ☐ hydrocortisone sodium succinate (Solu-CORTEF) 2 mg/kg = _____ mg, Soln, IVP, ONCE, **Max dose 100 mg**



100000067

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
August 2024

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

Height: _____ cm Weight: _____ kg

**OUTPATIENT INFLIXIMAB ORDERS –
PEDIATRIC**

Page 2 of 2

Medication:

Renflexis biosimilar is standard/preferred. If needing a different biosimilar indicate here: _____

Patient less than 15 kg: (NOT eligible for rapid infliximab infusion)

- ☐ inFLIXimab (Outpt Use Only) _____ mg/kg = _____ mg*, in 250 mL 0.9% Sodium Chloride, Soln, IVPB
(*Rounded by pharmacy to nearest 100 mg for patients greater than 60 kg; otherwise rounded to nearest 10 mg)
1. Infuse via a non-protein binding filter (1.2 micron or less);
 2. Infuse at 80 mL/hour X 30 minutes (volume 40 mL), then 150 mL/hour until infusion complete;
 3. **Maximum infusion rate 150 mL/hour**

Patient greater than or equal to 15 kg: (ELIGIBLE for rapid infliximab infusion)

- ☐ inFLIXimab (Outpt Use Only) _____ mg/kg = _____ mg*, in 250 mL 0.9% Sodium Chloride, Soln, IVPB
(*Rounded by pharmacy to nearest 100 mg for patients greater than 60 kg; otherwise rounded to nearest 10 mg)
1. Infuse via a non-protein binding filter (1.2 micron or less);
 2. Infuse at 80 mL/hour X 30 minutes (volume 40 mL), then 150 mL/hour X 30 minutes (volume 75 mL), then 225 mL/hour until infusion complete;
Total infusion no less than 2 hours
 3. Infuse 4th infusion over 90 minutes. Infuse 5th and successive infusions over 60 minutes.
 4. If dose increases, new dose must be administered using titratable rate noted above in #2 for 1 dose prior to resuming rapid infusions.
 5. Patients that experience a reaction must remain on titratable rate noted above in #2 (NOT eligible for rapid infliximab infusion).

Treatment Schedule:

- Initial Therapy:** ☐ One time dose **Maintenance:** ☐ Start _____ weeks from last administered dose
☐ Weeks 0, 2, and 6 ☐ Every 8 weeks
☐ Other: Weeks _____ ☐ Every _____ weeks

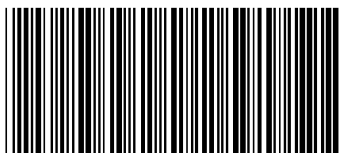
Treatment Duration:

- ☐ 6 months ☐ 1 year

Anaphylaxis:

- ☐ diphenhydramine (Benadryl) 1.25 mg/kg = _____ mg, Soln, IVP, ONCE, PRN anaphylaxis, **Max dose 50 mg**
☐ EPINEPHrine (EpiPen) 0.15 mg, Soln, IM, ONCE, PRN, anaphylaxis, **Less than 25 kg**
☐ EPINEPHrine (EpiPen) 0.3 mg, Soln, IM, ONCE, PRN, anaphylaxis, **Greater than or equal to 25 kg**
☐ methylPREDNISolone (SOLU-Medrol) 2 mg/kg = _____ mg, Soln, IVP, ONCE, PRN, anaphylaxis, **Max dose 125 mg**
☐ famotidine (Pepcid) 0.5 mg/kg = _____ mg, Soln, IVP, ONCE, PRN anaphylaxis, **Max dose 20 mg**
☐ albuterol 2.5 mg Soln, NEB, ONCE, PRN, Respiratory Distress, (2.5 mg/3 mL)
☐ racpinephrine 0.5mL, Soln, NEB, ONCE, PRN, Stridor

Other: _____



100000067

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
August 2024