Northern Light Health

☐ 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

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

Height: _____ cm **Weight:** _____ kg

OUTPATIENT INFLIXIMAB ORDERS – PEDIATRIC

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
☐ Comprehensive Metabolic Panel
☐ Infliximab Activity and Neutralizing Ab
☐ Erythrocyte Sedimentation Rate
☐ C-Reactive Protein
☐ Other: _____

Frequency: ☐ *Prior to each infusion*
☐ *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***

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Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS

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OUTPATIENT INFLIXIMAB ORDERS – PEDIATRIC

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*
☐ *Weeks 0, 2, and 6*
☐ *Other: Weeks* _____

Maintenance:
☐ *Start* _____ *weeks from last administered dose*
☐ *Every 8 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)*
☐ racepinephrine *0.5mL, Soln, NEB, ONCE, PRN, Stridor*

Other: _____

_____

_____

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

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