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 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

OP infliximab Adult (Paper)

Diagnosis ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylosis ☐ Plaque Psoriasis
☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other

ICD10: _____

Tuberculosis (TB) and Hepatitis B Testing

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/Hepatitis

Quantiferon TB Gold Test: Date: _____/_____/_____ Result: _____
T SPOT: Date: _____/_____/_____ Result: _____
Hepatitis B: Date: _____/_____/_____ Result: _____
Hepatitis C: Date: _____/_____/_____ Result: _____

Patient Care

☒ Vital Signs
ONCE, Pre and Post infusion

☒ Saline Lock
Insert peripheral Saline Lock, discontinue after therapy complete. May leave in for 5 consecutive treatment days

☐ Access PICC Line
☐ Remove PICC Line ONLY after verifying regimen is complete with provider
☐ Access Port-a-Cath
☐ Access Central Access Device (Hickman, Triple lumen)

Restoration of Patency for PICC/Port-a-cath

☐ alteplase
2 mg, ONCE, Catheter Clearance, If initial dose is ineffective after 2 hours, repeat dose. Notify provider if second dose is ineffective. Total Max dose = 2 doses

Premedication

☒ acetaminophen (Tylenol) *650 mg, PO, ONCE*
☒ cetirizine (Zyrtec) *10 mg, PO, ONCE*
☐ famotidine (Pepcid) *20 mg, PO, ONCE*
☐ methylprednisolone *40 mg, Soln, IVP, ONCE*
☐ methylprednisolone *125 mg, Soln, IVP, ONCE*
☐ methylprednisolone _____ *mg, Soln, IVP, ONCE*
☐ Sodium Chloride 0.9%, *500mL/hr, IV, ONCE, Infuse over 1 hour, if patient has port-a-cath infuse over 30 minutes*

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

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OP infliximab Adult (Paper)

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

Medication

Pharmacist can substitute infusion medication based on patient insurance coverage or NLH preferred biosimilar unless provider orders a specific brand, to include written rationale

Medication to be rounded by pharmacy to nearest 100 mg for patients greater than 60 kg, for patient 60 kg or less rounded to the nearest 10 mg

☐ Infliximab _____ *mg/kg (pharmacy to calculate final dose) =*_____

☐ Infliximab _____ *mg (flat dose)*

Brand of infliximab (to be completed by pharmacy once prior authorization complete):_____

Mix in 250 mL 0.9% Sodium Chloride, IVPB, via a non-protein binding filter (1.2 micron or less)
First 3 infusions: 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
Fourth infusion: Infuse over 90 minutes (no titration)
Fifth and successive infusions: Infuse over 60 minutes (no titration)
For patients that experience a reaction, they must remain on titratable rate noted above and are not eligible for the faster infusion rate.

Treatment Schedule:

☐ One time dose
Initial Therapy: ☐ Weeks 0, 2 and 6
Maintenance: ☐ Every 8 weeks ☐ Every _____ weeks

Duration: ☐ 6 months ☐ 1 year ☐ Other: _____

Pharmacy to dispense specific brand (include rationale for needing specific brand):_____

Anaphylaxis Treatment

☒ Epinephrine (EpiPen Auto Injector) *0.3 mg, Kit, IM, Every 5 Minute Interval, PRN, airway swelling, difficulty breathing, Indication: hypotension (systolic blood pressure less than 90). Max total dose = 0.9 mg (3 doses). May be given concurrently with diphenhydramine, famotidine and methylprednisolone based on indications*

☒ diphenhydramine (Benadryl) *50 mg, Soln, IV Push, ONCE, PRN, Indication: itching, hives, difficulty breathing or swelling of the face, lips and throat. May be given concurrently with epinephrine, famotidine and methylprednisolone based on indications*

☒ famotidine (Pepcid) *20 mg, Soln, IV Push, ONCE, PRN, Indication: angioedema, stomach upset. May be given concurrently with epinephrine, diphenhydramine and methylprednisolone based on indications*

☒ methylprednisolone (SOLU-Medrol) *125 mg, Soln, IV Push, ONCE, PRN, Indication: prevention of biphasic reaction, inflamed airway. May be given concurrently with epinephrine, diphenhydramine and famotidine based on indications*

☒ albuterol (Proventil NEB) *2.5 mg, Soln, NEB, ONCE, PRN, Indication: bronchospasm*

☒ Oxygen *Via: Nasal Cannula PRN Low oxygen saturation, Maintain saturation 90% or greater, wean as tolerated*

Other_____
_____

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

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Updated by CDS 05/2025
Re-print from CDS Portal to ensure most up to date content