477 W. Horton Rd.
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: ______________________________________

Date of Birth: ____________ Height: ________ Weight:_______

Allergies:__________________________________________

# Infliximab (or biosimilar) Order Form

Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to **(360) 933-1197** to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

**Has the patient previously received infliximab (Remicade):** ❑ No ❑ Yes: Brand_____________ Last Dose Date:______

**Diagnosis:** ❑ Crohn's Disease ❑ Rheumatoid Arthritis ❑ Ulcerative Colitis ❑ Psoriatic arthritis

**ICD-10:________** ❑ Plaque psoriasis ❑ Alkylosing Spondylitis ❑ Other: ______________________

CHF History? ❑ No ❑ Yes: NY Class __________(I-IV)

TB History: Date of last PPD or Quanterferon Gold: _______________ Result: ____________________

**Medication Orders:** ♦**Infliximab (Brand will be selected by pharmacy based on insurance contract formulary preference)**

Therapeutically interchangeable Infliximab products: • Remicade (infliximab) • Inflectra (infliximab-dyyb) • Renflexis (infliximab-abda) • Ixifi (infliximab-qbtx) • Avsola (infliximab-axxq)

Frequency: ❑ One dose ❑ 3 doses (at 0, 2, and 6 weeks) ❑ Maintenance every _____ weeks
❑ 3 doses (at 0, 2, and 6 weeks) followed by infusions every _____ weeks thereafter

Dose: RPh will round UP to nearest 100 mg vial, or ❑ Give exact dose (do NOT round)
❑ 5mg/kg**
❑ 3mg/kg** **Dose based on actual body weight
❑ Other: ______ mg/kg**

- ♦ Dilute in 0.9% Sodium Chloride to a final concentration of 0.4 to 4 mg/ml. Use an in-line filter 1.2 microns or smaller.
- ♦ Do not infuse other medications through the same IV tubing.
- ♦ Infuse over at least 2 hours. Begin at 10ml/hr and increase rate according to Infusion Rate Chart. → → → → → → →
- ♦ If change in vital signs (ie: diastolic blood pressure drops 15-20 mmHg) or adverse reaction (ie: urticaria, shortness of breath) occurs, slow or stop infusion immediately. After symptoms have resolved, may resume titration starting at 10ml/hr.

**Infusion Rate Chart**

| Infusion Rate | Time (min) |
|---|---|
| 10 ml/hr | For 15 minutes |
| 20 ml/hr | For 15 minutes |
| 40 ml/hr | For 15 minutes |
| 80 ml/hr | For 15 minutes |
| 150 ml/hr | For 30 minutes |
| 250 ml/hr | Until end of therapy |

Premedication (15 minutes before infusion):

Diphenhydramine ❑ 50mg IV ❑ 25mg IV
Acetaminophen ❑ 1000mg PO ❑ 500mg PO

- ♦ Other: ____________________________________________

Ancillary Orders:

- ♦ Infusion Reaction Management per Infusion Solutions Protocol.
- ♦ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- ♦ Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- ♦ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

**Nursing Orders:**

- ♦ If no central IV access, RN to insert peripheral IV.
- ♦ Weight should be taken before each dose.
- ♦ Monitor vital signs (pulse & blood pressure) before therapy and every 15 to 30 min until 30 min after therapy.
- ♦ If an infusion reaction occurs, decrease rate and monitor vital signs until symptoms subside. If reaction persists or worsens, stop infusion and notify physician.
- ♦ Observe patient for 30 minutes after completion of therapy.
- ❑ Other: ____________________________________________

**Labs:**

❑ CBC with Diff ❑ at each dose ❑ every ____________
❑ Hepatic function panel ❑ at each dose ❑ every ____________
❑ CRP ❑ at each dose ❑ every ____________
❑ Other: ______________________________ ❑ every ____________

_________________________________ _______________
*Prescriber Signature* *Date*

_________________________________
*Please Print Name*

**KEY: ♦ Orders are initiated unless crossed out by provider.** ❑ **Check to initiate order.**

Form #302
Updated 1/20/2025 -AF