BioTek reMEDys

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Infliximab (Remicade®) Order Form

PATIENT INFORMATION

Patient Name: _____ Date: _____

Address: _____ Phone: _____

City, State, Zip: _____

DOB: _____ Weight: _____ Height: _____ **Diabetic (Circle one):** Yes / No

Diagnosis / ICD 10 Code: _____ Allergies: _____

☐ **INITATION OF THERAPY** ☐ **CHANGE OF INTERVAL** ☐ **CHANGE OF PROVIDER**

If the patient cannot provide recent PPD results (within12 months), then perform PPD.

TUBERCULOSIS SCREENING: ☐ PPD **Date Performed:** _____ **Date Read**: _____

☐ PPD results provided by patient per Dr. _____ **Date**: _____

Result: ☐ Negative → May Initiate Remicade® Therapy

☐ Positive → ☐ Chest X-Ray performed **Date Performe**d: _____ ☐ Negative result → May initiate Remicade®

☐ Positive result → TB treatment initiated

☐ RN to teach disease management

Remicade® - Choose Regimen:

☐ 3 mg/kg _____ mg/NS 0.9% 250 mL IV over 2 hours

☐ 5 mg/kg _____ mg/NS 0.9% 250 mL IV over 2 hours

☐ 10 mg/kg _____ mg/NS 0.9% 250 mL IV over 2 hours

☐ _____mg/kg _____mg/NS 0.9% 250 mL IV over 2 hours

☐ Repeat dose in 2 weeks and then every 6 weeks

☐ NS 0.9% 50 mL IVPB to flush Remicade from IV tubing

☐ Concomitant po Methotrexate _____mg/week (Methotrexate RX given to Patient)

☐ Repeat dose at weeks 2 and 6, and then every 8 weeks

☐ Other frequency: _____

Duration of Therapy: ☐ x 1 year

☐ Other: _____

*** Start infusion at 10 mL/hr. Double the rate after 15 minutes (as tolerated) for the first hour of infusion. (After first 15 minutes → 20 mL/hr, at 30 minutes → 40 mL/hr, at 45 minutes → 80 mL/hr, at 1 hr →160 mL/hr). At 90 minutes into the infusion, the rate may be increased for the last time to a maximum rate of 250 mL/hr.**

Pre-Medications:

☐ **Diphenhydramine** _____mg, po **-or-** IV **(circle one)**, prior to start of infusion

☐ **Acetaminophen** 650 mg po prior to start of infusion

☐ **Prednisone** _____mg, po **-or-** ☐ Methylprednisolone 40 mg IVP **-or-** ☐ Hydrocortisone 100 mg IVP

☐ **Other:** _____

*** Administer pre-medications 15 to 30 minutes prior to start of infusion ***

IV Access:

☐ Start PIV if no IV access available ☐ Maintain current central line access

Catheter Care:

☐ Sodium Chloride 0.9% _____ mL IV before and after each IV access and PRN per protocol

☐ Sodium Chloride 0.9% _____ mL as above **AND** Heparin 100 Units /mL _____ mL IV flush after second saline flush and PRN

* Dressing changes weekly and PRN

* Antimicrobial dressing PRN

* May obtain blood from IV access for labs

* May use Cathflo 2 mg/2 mL sterile water IVP 2 mL per lumen; May repeat after 2 hours' x 1

Labs:

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ X-ray _____ ☐ Other _____

Standard Orders for Side Effects:

☐ **Promethazine** 25 mg – 1-2 tabs po q 4-6 hrs PRN nausea / vomiting

☐ **Acetaminophen** 325 mg - 2 tabs po q 4-6 hrs PRN HA, myalgia, fever

☐ **Promethazine** 25 mg IV/IM **x** 1 dose PRN nausea / vomiting

☐ **Diphenhydramine** 25 mg - 1 to 2 caps po PRN

☐ **Diphenhydramine** 25 mg **-or-** 50 mg IV **x** 1 dose PRN

☐ **Other**: _____

Monitoring Parameters:

☐ Obtain vital signs and temperature q 15 mins for the 1st hour, then q 30 mins for the remainder of the infusion

☐ Observe patient for 30 mins following the infusion

☐ Instruct patient to report symptoms of chills, fever, headache, sore throat, pain, etc.

☐ Other: _____

Anaphylactic Reaction (AR):

Epinephrine (based on patient weight)

EpiPen® Auto-injector 0.3 mg (1:1000) - Inject IM **-or-** SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins **x** 1 if necessary

EpiPen Jr® Auto-injector 0.15mg (1:2000) - Inject IM **-or-** SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins **x** 1 if necessary

Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat **x** 1 after 10 mins, if necessary

Hydrocortisone 100mg - Give 100 mg IVP **-or-** IM if no IV access

Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr

Other Orders: _____

Prescribing Physician: _____ Address: _____ Phone: _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

Fax completed form to: (800-783-9146) - Thank you for using BioTek reMEDys®