NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-307-2244
Phone: 405-515-2470

ORD

InFLIXimab

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment: _____

Laboratory

☑ CBC WITH DIFFERENTIAL ☑ COMPREHENSIVE METABOLIC PANEL

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port
☑ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

Premedication

☐ DiphenhydrAMINE (Benadryl) 25 MG ORAL ONCE
☐ Acetaminophen (Tylenol) 325MG 2 TAB ORAL ONCE
☐ HydrocorTISone Succinate (Solu-Cortef) 100 MG IV PUSH ONCE (J1720 : 100 MG = 1 unit)

Infusion

☐ **InFLIXimab (Remicade) [J1745 : 10 MG = 1 unit]**
☐ **InFLIXimab-dyyb (Inflectra) [Q5103 : 10 MG = 1 unit]**
☐ **InFLIXimab-abda (Renflexis) [Q5104 : 10 MG = 1 unit]**
☐ **InFLIXimab-axxq (Avsola) [Q5121 : 10 MG = 1 unit]**

*****Dose will be rounded to NO GREATER THAN 10% of original calculated dose for appropriate vial usage.**

Initial Dosing

☐ InFLIXimab _____ milligram/kilogram INTRAVENOUS ONCE x 3 doses. Start infusion at 10 milliliters/hour for 15 minutes, if tolerated increase to 20 milliliters/hour for 15 minutes, if tolerated increase to 40 milliliters/hour for 15 minutes, if tolerated increase to 80 milliliters/hour for 15 minutes, if tolerated increase to 120 milliliters/hour for 15 minutes, if tolerated increase to 240 milliliters/hour for 15 minutes.

Date of Service: First Dose _____ - next initial dose in 2 weeks, last initial dose in 6 weeks, then in 8 weeks begin maintenance dose.

Maintenance Dose

☐ InFLIXimab _____ milligram/kilogram INTRAVENOUS ONCE EVERY 8 WEEKS. Start infusion at 10 milliliters/hour for 15 minutes, if tolerated increase to 20 milliliters/hour for 15 minutes, if tolerated increase to 40 milliliters/hour for 15 minutes, if tolerated increase to 80 milliliters/hour for 15 minutes, if tolerated increase to 120 milliliters/hour for 15 minutes, if tolerated increase to 240 milliliters/hour for 15 minutes

Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

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DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES