# Oregon Medical Group Infusion Center

1007 Harlow Road, Springfield, Oregon 97477
Phone: 541-741-0387   Fax: 541-242-4634

**Infliximab (Inflectra, Remicade) Orders**

Name: ______________________________________ DOB: _____________________________

Diagnosis/Indication: ___________________________ ICD-10 Code: ________________________

Weight: ___________________ Height: ___________ BSA:______________________________

**Please check medication to order:**
☐ Remicade (infliximab)   ☐ Inflectra (infliximab-dyyb)   ☐ Other: ___________________________

**Dosing Regimen:**
☐ 3 mg/kg at 0, 2, and 6 weeks followed by 3 mg/kg every 8 weeks thereafter
☐ 5 mg/kg at 0, 2, and 6 weeks followed by 5 mg/kg every 6 weeks thereafter
☐ 5 mg/kg at 0, 2, and 6 weeks followed by 5 mg/kg every 8 weeks thereafter
☐ 10 mg/kg every _____ weeks
☐ _____ mg/kg every _______ weeks
☐ Other, please specify: ________________________________________________________

Dose rounding:
☐ RN will use most recent weight and round dose to the nearest 100 mg vial (recommended)
☐ Use exact dose as calculated. Do not round. If selected, please indicate reason for medical necessity:
_____________________________________________________________________________

1. Peripheral IV site with saline lock, may use existing PICC line or port-a-cath if available.
2. Vital signs: Initial, Q 15-30 minutes, PRN
3. Pre-medications to be given 30 minutes prior to infusion
   - ☐ OMG Infusion Center Pre-Medication Protocol
   
   **OR**
   - ☐ Administer the following routine pre-medications prior to each infusion
     - ☐ Acetaminophen (Tylenol) 650 mg PO
     - ☐ Antihistamine (Select one)
       - ☐ Diphenhydramine (Benadryl) 25 mg PO
       - ☐ Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins
       - ☐ Loratadine (Claritin) 10 mg PO
     - ☐ Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min
     - ☐ Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min
     - ☐ Ondansetron 4 mg IV **OR** ☐ Ondansetron 8 mg IV
   - ☐ Other: __________________________________________________________
4. For infusion reaction (**Must select one to be considered a complete order**)
   
   ☐ Acute Infusion Reaction Protocol
   ☐ Other ___________________________________________________________
5. Dose Ramping Guidelines
   
   Infuse ≥ 2 hours
   May accelerate infusion rate as tolerated, if no history of infusion reaction

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| Infusion Rate (per hour) | Amount to be infused (over 15 minutes) |
|---|---|
| 10 mL | 3 mL |
| 20 mL | 5 mL |
| 40 mL | 10 mL |
| 80 mL | 20 mL |
| 150 mL | 75 mL |
| 250 mL | 125 mL |

Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order (non-OMG providers). A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order (non-OMG providers).

Provider Signature: ____________________________________ Date: ___________
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: _________________________________Time: __________

Patient Name: _________________________________________DOB: __________