



PHYO
CMC85137-002NS Rev. 11/2021

**CHST INFLIXIMAB
(REMICADE or BIOSIMILAR)
INFUSION THERAPY PLAN (NEUROLOGY)**

Patient Name: _____

Date of Birth: _____

Baseline Patient Demographic

To be completed by the ordering provider.

Diagnosis: _____ Height: _____ cm Weight: _____ kg Body Surface Area: _____ (m²)

☐ NKDA - No Known Drug Allergies ☐ Allergies: _____

Therapy Plan orders extend over time (several visits) including recurring treatment.

Please specify the following regarding the entire course of therapy:

Duration of treatment: _____ weeks _____ months _____ unknown

Treatment should begin: ☐ as soon as possible (within a week) ☐ within the month

****Plans must be reviewed / re-ordered at least annually. ****

ORDERS TO BE COMPLETED FOR EACH THERAPY

ADMIT ORDERS

☒ Height and weight

☒ Vital signs

HYPOTENSION DEFINED ADMIT

☒ Nursing communication

Prior to starting infusion, please determine the patient's threshold for hypotension as defined by the following parameters. This information will be needed in the event of an infusion reaction.

Hypotension is defined as follows:

1 month to 1 year - systolic blood pressure (SBP) less than 70

1 year to 11 years - systolic blood pressure (SBP) less than 70 + (2 x age in years)

11 years to 17 years - systolic blood pressure (SBP) less than 90

OR any age - systolic blood pressure (SBP) drop of more than 30% from baseline.

Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.

PREGNANCY TESTS AT DALLAS AND PLANO

Nursing communication

Only one pregnancy test is necessary, based on facility capabilities. Please utilize the lab that is available per facility.

☐ Patient requires a pregnancy test (based on organizational policy, female patients over 10 require a pregnancy test)

Pregnancy test, urine - POC

STAT, ONE TIME, for females > 10 years old. If positive, do NOT infuse and contact the ordering provider.

Gonadotropin chorionic (HCG) urine

STAT, ONE TIME, unit collect, for females > 10 years old. If positive, do NOT infuse and contact the ordering provider.

NURSING ORDERS

☒ Nursing communication

Confirm TB test is negative within last year, if no test or positive, contact ordering provider.

IV START NURSING ORDERS

☒ Insert peripheral IV / Access IVAD

Place PIV if needed or access IVAD if available

☐ lidocaine 1% BUFFERED (J-TIP LIDOCAINE)

0.2 mL, INTRADERMAL, PRN

☐ when immediate procedure needed ☐ when procedure will take about 1 minute ☐ patient / family preference for procedure

Administration Instructions: NOTE: Do not use this medication in patients with bleeding disorders, platelets $\leq$ 20,000, or in patients taking anticoagulants, when accessing implanted ports or using a vein that will be utilized for chemotherapy administration, nor for pre-term infants or neonates.



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ORDERS TO BE COMPLETED FOR EACH THERAPY**NURSING ORDERS, CONTINUED**

Please select all appropriate therapy

☐ **lidocaine - prilocaine (EMLA) cream**

TOPICAL, PRN

☐ when more than 60 minutes are available before procedure ☐ when procedure will take more than 1 hour☐ patient / family preference for procedure

Administration Instructions: NOTE: In children < 3 months of age, or < 5 kg in weight, maximum application time is 1 hour.

☐ **lidocaine - tetracaine (SYNERA) patch**

TOPICAL, PRN

☐ when 20 - 30 minutes are available before procedure ☐ when procedure will take more than 1 hour☐ when anticipated pain is less than 5 mm from skin surface ☐ patient / family preference for procedure☐ **lidocaine with transparent dressing 4% kit**

TOPICAL, PRN

☐ when 20 - 30 minutes are available before procedure ☐ when procedure will take more than 1 hour☐ patient / family preference for procedure☐ **Heparin flush****heparin flush**

10 - 50 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. This heparin flush should be used with all central lines including IVADs, with the exception of de-accessing the IVAD.

heparin flush

100 - 300 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. For use only when de-accessing IVADs.

☐ **Sodium chloride flush****Sodium chloride flush 0.9% injection**

1 - 20 mL, INTRAVENOUS, PRN, IV line flush

Sodium chloride - preservative free 0.9% injection

1 - 30 mL, INTRAVENOUS, PRN, IV line flush

PRE-PROCEDURE LABS☐ **Complete Blood Count With Differential****INTERVAL:** Every 12 weeks**DEFER UNTIL:** _____**DURATION:**

Unit Collect

After 3rd infusion and then every 3 months

Hepatic Function Panel**INTERVAL:** Every 12 weeks**DEFER UNTIL:** _____**DURATION:**

Unit Collect

After 3rd infusion and then every 3 months

PRE-MEDICATIONS☐ **Acetaminophen pre-medication 30 minutes prior (15 mg / kg, maximum 650 mg)****Nursing communication**

Administer only one of the Acetaminophen pre-medication orders, suspension or tablets, do not give more than one of the orders as a pre-medication.

acetaminophen suspension

15 mg / kg, ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion

Dose: _____**acetaminophen tablet**

15 mg / kg ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion

Dose: _____



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ORDERS TO BE COMPLETED FOR EACH THERAPY**PRE-MEDICATIONS, CONTINUED**
☐ **Diphenhydramine pre-medication 30 minutes prior (1 mg / kg, maximum 50 mg)**
Nursing communication

Administer only one of the diphenhydrAMINE pre-medication orders, liquid, capsule or injection, do not give more than one of the orders as a pre-medication.

diphenhydrAMINE liquid

1 mg / kg, ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion

Dose: _____**diphenhydrAMINE capsule**

1 mg / kg ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion

Dose: _____**diphenhydrAMINE injection**

1 mg / kg, INTRAVENOUS, 1 dose pre-medication, give 30 minutes prior to infusion

Dose: _____
☐ **methyIPREDNISolone RTA infusion 1 mg / kg** **INTERVAL:** Every visit

1 mg / kg INTRAVENOUS, ONCE for 1 dose. Pre-medication, give 30 minutes prior to infusion. For doses ≥ 10 mg / kg see Policy 7.10.16, assess and document heart rate and blood pressure (BP) every 15 minutes during infusion and for 1 hour after the infusion is complete. Doses > 15 mg / kg should be given over a minimum of 1 hour.

Dose: _____
☐ **cetirizine tablet**

10 mg ORAL, ONCE for one dose. Pre-medication, give 30 minutes prior to infusion.

Dose: _____**INTRA-PROCEDURE**
☒ **Vital signs**

Obtain baseline vitals prior to start of inFLIXimab, then monitor vitals every 15 minutes during inFLIXimab infusion and for 30 minutes after the infusion is completed.

☒ **Nursing Communication**

	Rate	Time at that rate
Initial Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	Maximum 250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

☒ **Physician Communication Order**

Recommended inFLIXimab starting dose = 5 mg / kg. Please enter the dose of inFLIXimab in "mg" to facilitate prior authorization requirements. Vial size is 100 mg, if possible and clinically acceptable, round to nearest 100 mg.

Infliximab (REMICADE or biosimilar) - Loading Dose**Select one product:**
☐ **inFLIXimab (REMICADE)**
INTERVAL: Every 14 days **Defer Until:** _____ **DURATION:** 3 Treatments
in sodium chloride 0.9% 250 mL infusion

Intravenous, at 125 mL / hr for 1 dose, administer over 2 hours. Must be administered with a 0.2 micron disk filter. Time (minutes) infusion rate.

Dose: _____ mL

	Rate	Time at that rate
Initial Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	Maximum 250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete



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Patient Name: _____

Date of Birth: _____

ORDERS TO BE COMPLETED FOR EACH THERAPY

INTRA-PROCEDURE, CONTINUED

- ☐ **inFLIXimab-dyyb (INFLECTRA)
in sodium chloride 0.9% 250 mL infusion** **INTERVAL:** Every 14 days **Defer Until:** _____ **DURATION:** 3 Treatments
Intravenous, at 125 mL / hour for 1 dose, administer over 2 hours. Must be administered with a 0.2 micron disk filter. Time (minutes) infusion rate

Dose: _____

	Rate	Time at that rate
Initial Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	Maximum 250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

- ☐ **inFLIXimab-abda (RENFLEXIS)
in sodium chloride 0.9% 250 mL infusion** **INTERVAL:** Every 4 weeks **Defer Until:** _____ **DURATION:** Until discontinued
Intravenous, at 125 mL / hour for 1 dose, administer over 2 hours. Must be administered with a 0.2 micron disk filter. Time (minutes) infusion rate

Dose: _____

	Rate	Time at that rate
Initial Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	Maximum 250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Infliximab (REMICADE or biosimilar) - Maintenance Dose

Select one product below:

- ☐ **inFLIXimab (REMICADE)
in sodium chloride 0.9% 250 mL infusion** **INTERVAL:** Every 4 weeks **Defer Until:** _____ **DURATION:** Until discontinued
Intravenous, at 125 mL / hr for 1 dose, administer over 2 hours. Must be administered with a 0.2 micron disk filter. Time (minutes) infusion rate.

Dose: _____ mL

	Rate	Time at that rate
Initial Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	Maximum 250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

- ☐ **inFLIXimab-dyyb (INFLECTRA)
in sodium chloride 0.9% 250 mL infusion** **INTERVAL:** Every 4 weeks **Defer Until:** _____ **DURATION:** Until discontinued
Intravenous, at 125 mL / hr for 1 dose, administer over 2 hours. Must be administered with a 0.2 micron disk filter. Time (minutes) infusion rate.

Dose: _____ mL

	Rate	Time at that rate
Initial Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	Maximum 250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete



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INTRA-PROCEDURE, CONTINUED

☐ inFLIXimab-abda (RENFLEXIS)

INTERVAL: Every 14 days Defer Until: _____ DURATION: 3 Treatments

in sodium chloride 0.9% 250 mL infusion

Intravenous, at 125 mL / hour for 1 dose, administer over 2 hours. Must be administered with a 0.2 micron disk filter. Time (minutes) infusion rate

Dose: _____

	Rate	Time at that rate
Initial Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	Maximum 250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

☒ Therapy Appointment Request

Please select department for the therapy appointment request:

Expires in 365 days

☐ Dallas Special Procedures ☐ Plano Infusion Center ☐ Dallas Allergy ☐ Dallas Transplant ☐ Dallas Neurology

EMERGENCY MEDICATIONS

☒ Nursing communication1. Hives or cutaneous reaction only – no other system involvement: **PATIENT IS HAVING A DRUG REACTION**

- Stop the infusion
- Give diphenhydramine as ordered
- Check vitals including blood pressure every 5 minutes until further orders from provider.
- Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation) if not already on one
- Notify provider for further orders

2. Hives or cutaneous reaction plus one other system, i.e. abdominal cramping, vomiting, hypotension, altered mental status, respiratory distress, mouth / tongue swelling: **PATIENT IS HAVING ANAPHYLAXIS**

- Stop the infusion
- Call code – do not wait to give epinephrine
- Give epinephrine as ordered
- Notify provider
- Check vitals including blood pressure (BP) every 5 minutes until the code team arrives.
- Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation), if not already on one.
- Give diphenhydramine once as needed for hives
- May repeat epinephrine every 5 minutes x 2 doses for persistent hypotension and respiratory distress with desaturation until code team arrives.
- May give albuterol as ordered for wheezing with oxygen saturation stable while waiting for code team – continue to monitor oxygen saturation.

Hypotension is defined as follows:

- 1 month to 1 year – systolic blood pressure (SBP) less than 70
- 1 year to 11 years – systolic blood pressure (SBP) less than $70 + (2 \times \text{age in years})$
- 11 years to 17 years – systolic blood pressure (SBP) less than 90
- OR any age – systolic blood pressure (SBP) drop more than 30% from baseline.
- Baseline systolic blood pressure (SBP) $\times 0.7$ = value below defined as hypotension.

☒ EPINEPHrine Injection Orderable For Therapy Plan
(AMPULE / EPI - PEN JR. / EPI - PEN) 0.01 mg / kg

0.01 mg / kg, INTRAMUSCULAR, EVERY 5 MINUTES PRN, for anaphylaxis and may be repeated for persistent hypotension and respiratory distress with desaturation until the code team arrives, for 3 doses

Use caution with PIV administration. This solution has a pH < 5, or a pH > 9, or an osmolality > 600 mOsm / L.

Dose: _____



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EMERGENCY MEDICATIONS, CONTINUED

☐ Cardio / Respiratory Monitoring

Rationale for Monitoring: High risk patient (please specify risk)

- ☐ Clinically significant cardiac anomalies or dysrhythmias
- ☐ Recent acute life-threatening event
- ☐ Unexplained or acutely abnormal vital signs
- ☐ Artificial airway (stent, tracheostomy, oral airway)
- ☐ Acute, fluctuating or consistent oxygen requirements

Monitor Parameters (select all that apply): ☐ Heart rate ☐ Oxygen saturation ☐ Respiratory rateTelemetry Required: ☐ Yes ☐ No☒ diphenhydrAMINE injection

1 mg / kg, INTRAVENOUS, ONCE PRN, for hives or cutaneous reaction, for 1 dose. Maximum dose = 50 mg per dose, 300 mg per day.

Dose: _____

☒ Albuterol for aerosol

0.25 mg / kg., INHALATION ONCE PRN, for wheezing, but oxygen saturations stable while waiting for code team, continue to monitor oxygen saturation for 1 dose.

Dose: _____

POST - PROCEDURE

☒ Nursing communication

Flush PIV or IVAD with 20 mL 0.9% sodium chloride (250 mL bag) at the completion of the infusion.
Flush IVAD with saline and heparin flush per protocol prior to de-accessing IVAD.
Discontinue PIV prior to discharge.

☒ Sodium chloride 0.9% infusion

INTRAVENOUS, at 0 -25 mL / hour, ONCE, for 1 dose

Dose: _____

(circle one):
MD DO

Signature of Provider

Credentials

Date

Time

Printed Name of Provider