



PHYO
CMC84734-001NS Rev. 1/2021

**InFLIXimab (REMICADE)
(Rheumatology) - Therapy Plan**

Patient Name: _____

Date of Birth: _____

Baseline Patient Demographic

To be completed by the ordering provider.

☐ NKDA - No Known Drug Allergies Height: _____ cm Weight: _____ kg Body Surface Area: _____ (m²)

☐ 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, but two are available based on facility capabilities. There is a urine POC HCG and urine HCG. Please utilize the lab that is needed based on facility capabilities.

Select One:

☐ Pregnancy test, urine - POC

STAT, ONE TIME, for females > 10 years old. If positive, do NOT infuse and page on-call provider

☐ Gonadotropin Chorionic (HCG) Urine

STAT, ONE TIME, unit collect. For females > 10 years old. If positive, do NOT infuse and page on-call provider.

NURSING ORDERS

Please select all appropriate therapy

IV START NURSING ORDERS

☐ Insert Peripheral IV

Place PIV if needed or access IVAD if available.



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ORDERS TO BE COMPLETED FOR EACH THERAPY

NURSING ORDERS

Please select all appropriate therapy

- ☐ **Lidocaine 1% BUFFERED (J - TIP LIDOCAINE) injection**
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.

- ☐ **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

Select One:

- ☐ **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 0.9% injection**
1 - 20 mL, INTRAVENOUS, PRN, IV line flush

- ☐ **sodium chloride - pres free 0.9% injection**
1 - 30 mL, INTRAVENOUS, PRN, IV line flush

PRE-PROCEDURE LABS

- ☒ **Complete blood count with differential (CBC)**
Unit collect with initial infusion, then every 8 weeks
beginning with maintenance dose at week 6.

once beginning _____

- ☒ **Complete blood count with differential (CBC)**
Unit collect

every 8 weeks



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ORDERS TO BE COMPLETED FOR EACH THERAPY

PRE-PROCEDURE LABS

- | | |
|---|----------------------|
| ☒ Aspartate Aminotransferase
Unit collect with initial infusion, then every 8 weeks
beginning with maintenance dose at week 6. | once beginning _____ |
| ☒ Aspartate Aminotransferase
Unit collect | every 8 weeks |
| ☒ Alanine Aminotransferase
Unit collect with initial infusion, then every 8 weeks
beginning with maintenance dose at week 6. | once beginning _____ |
| ☒ Alanine Aminotransferase
Unit collect | every 8 weeks |
| ☒ Sedimentation Rate Erythrocyte
Unit collect with initial infusion, then every 8 weeks
beginning with maintenance dose at week 6. | once beginning _____ |
| ☒ Sedimentation Rate Erythrocyte
Unit collect | every 8 weeks |
| ☒ Creatinine
Unit collect with initial infusion, then every 8 weeks
beginning with maintenance dose at week 6. | once beginning _____ |
| ☒ Creatinine
Unit collect | every 8 weeks |
| ☒ Albumin
Unit collect with initial infusion, then every 8 weeks
beginning with maintenance dose at week 6. | once beginning _____ |
| ☒ Albumin
Unit collect | every 8 weeks |
| ☒ Double stranded DNA antibody IgG
Unit collect with initial infusion, then every 16 weeks
beginning with maintenance dose at week 14. | once beginning _____ |
| ☒ Double stranded DNA antibody IgG
Unit collect | every 16 weeks |
| ☒ Complement C3
Unit collect with initial infusion, then every 16 weeks
beginning with maintenance dose at week 14. | once beginning _____ |
| ☒ Complement C3
Unit collect | every 16 weeks |
| ☒ Complement C4
Unit collect with initial infusion, then every 16 weeks
beginning with maintenance dose at week 14. | once beginning _____ |
| ☒ Complement C4
Unit collect | every 16 weeks _____ |



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ORDERS TO BE COMPLETED FOR EACH THERAPY

PRE-PROCEDURE, CONTINUED	INTERVAL
☒ Complement - total - CH50 Unit collect with initial infusion, then every 16 weeks beginning with maintenance dose at week 14	once beginning _____
☒ Complement - total - CH50 Unit collect	every 16 weeks

PRE-MEDICATIONS

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

Administer only one of the acetaminophen orders, suspension or tablets, do not give both.

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: _____

- ☐ **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: _____

- ☐ **methylPREDNISolone RTA infusion (1 mg / kg, maximum: 40 mg)**

1 mg / kg INTRAVENOUS, ONCE, pre-medication, give 30 minutes prior to infusion, For doses $\geq$ 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: _____

INTRA-PROCEDURE

- ☒ **Baseline vitals prior to start of inFLIXimab, then monitor vitals every 15 minutes during inFLIXimab infusion and for 30 minutes after infusion completed.**

- ☐ **Nursing communication**

InFLIXimab infusion rates: must be administered with a 0.2 micron disk filter.

Time (minutes) infusion rate

	Rate	Time at that rate
Initial Therapy 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	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete



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**InFLIXimab (REMICADE)
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ORDERS TO BE COMPLETED FOR EACH THERAPY
PRE-MEDICATIONS, CONTINUED
☐ **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 the nearest 100 mg.

inFLIXimab, loading dose
☐ **inFLIXimab in sodium chloride 0.9% 250 mL infusion**
Every 14 days
For 2 treatments

INTRAVENOUS, at 125 mL / hr, ONCE, must be administered with a 0.2 micron disk filter.

	Rate	Time at that rate
Initial Infusion 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	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

inFLIXimab, treatment dose
☐ **inFLIXimab in sodium chloride 0.9% 250 mL infusion**
Every 4 weeks
Until Discontinued

INTRAVENOUS, at 125 mL / hr, ONCE, for administer over 2 hours. Must be administered with a 0.2 micron disk filter.

Time (minutes) infusion rate

	Rate	Time at that rate
Initial Infusion 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	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

☐ **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 the nearest 100 mg. The following order is for maintenance dosing every 4 weeks, starting at week 6.

☐ **inFLIXimab in sodium chloride 0.9% 250 mL infusion**
Every 4 weeks
Until Discontinued

INTRAVENOUS, at 125 mL / hr, ONCE, for administer over 2 hours.

Must be administered with a 0.2 micron disk filter.

Time (minutes) infusion rate

	Rate	Time at that rate
Initial Infusion 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	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____



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ORDERS TO BE COMPLETED FOR EACH THERAPY

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 communication**

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

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

- a. Stop the infusion
- b. Call code – do not wait to give epinephrine
- c. Give epinephrine as ordered
- d. Notify provider
- e. Check vitals including blood pressure every 5 minutes until the code team arrives.
- f. Connect patient up to monitor (cardiac / apnea, blood pressure and oxygen saturation), if not already on one.
- g. Give diphenhydramine once as needed for hives
- h. May repeat epinephrine every 5 minutes x 2 doses for persistent hypotension and respiratory distress with desaturation until code team arrives.
- i. May give albuterol as ordered for wheezing with oxygen saturations 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 x age in years)
 11 years to 17 years – systolic blood pressure (SPB) less than 90
 OR any age – systolic blood pressure (SPB) drop more than 30% from baseline.
 Baseline systolic blood pressure x 0.7 = value below defined as hypotension.

☐ **Cardio / respiratory monitoring rationale for monitoring:**

High risk patient (please specify risk)

(Patient receiving infusion with potential infusion reactions);
 heart rate, respiratory rate, oxygen saturation

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

Parameters: heart rate, respiratory rate, oxygen saturation

Alarm limits: preset at age specific limits

☐ **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: _____



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Flush PIV or IVAD with 10 - 20 mL 0.9% sodium chloride at the completion of the infusion. Flush IVAD with saline and heparin flush per protocol prior to de - accessing IVAD.

☒ **sodium chloride flush 0.9%**

10 - 20 mL, INTRAVENOUS, PRN, IV line flush

Dose: _____

(circle one):
MD DO

Signature of Provider_____
Credentials_____
Date_____
Time_____
Printed Name of Provider