1. **ALLERGIES/REACTIONS:**

2. **DIAGNOSIS:**
   - Rheumatoid Arthritis
   - Crohn’s Disease
   - Psoriatic Arthritis
   - Ankylosing Spondylitis
   - Ulcerative Colitis
   - Plaque Psoriasis

3. **DIAGNOSIS/ICD-CM CODE(S):** ____________________________

4. **CURRENT MEDICATIONS:**

5. **LABS: (Prior to 1st Dose)**
   - Verify **TUBERCULOSIS TESTING (TB)** has been done. If not done, conduct one of the following tests PRIOR to initiating the first dose of infliximab (Remicade.)
     - PPD skin test if patient not on a steroid
     - High-risk patients: Quantiferon TB Gold, CXR
   - Verify **HEPATITIS B CORE ANTIBODY, TOTAL and HEPATITIS B SURFACE ANTIGEN (HBsAg)** have been done. If not done, initiate test(s) PRIOR to the first dose of infliximab (Remicade).

6. **INFLIXIMAB-DYYB (INFLECTRA) ADMINISTRATION:**
   - **INFLIXIMAB (REMICADE) ADMINISTRATION:**
     - Rheumatoid Arthritis: 3 mg/kg
     - Ankylosing Spondylitis: 5 mg/kg
     - Psoriatic Arthritis: 5 mg/kg
     - Plaque Psoriasis: 5 mg/kg
     - Crohn’s Disease: 5 mg/kg, 10 mg/kg
     - Ulcerative Colitis: 5 mg/kg
     - Other: __________________________________________ mg/kg

7. **Height:** __________ cm  **Actual Weight:** __________ kg

8. **CALCULATED DOSE:** __________ mg
   - Dose rounding preference:
     - Round to nearest 100 mg
     - Round to nearest vial size if the rounded dose is within _____% of the calculated dose. If unable to round to the nearest vial size, the dose will be rounded to the nearest ml increment practical for admixture.

9. **INFLIXIMAB – DYYB (INFLECTRA) DOSE FREQUENCY:**
   - **INFLIXIMAB (REMICADE) DOSE FREQUENCY:**
     - Three Doses (Day 0, 2 weeks, 6 weeks) followed by infusions every 6 weeks thereafter OR
     - Three Doses (Day 0, 2 weeks, 6 weeks) followed by infusions every 8 weeks thereafter OR

10. **OTHER MEDICATIONS:**
    - Nurse May Initiate IV Catheter Care, Outpatient Physician Order #858
    - For Infusion Reactions Initiate Drug Related Hypersensitivity Physician Order #774

**Physician Initial:____________________**
10. **OTHER MEDICATIONS:** (Continued)

**Pre-medication:** Give 30 minutes prior to infusion
- Diphenhydramine (Benadryl) 25 mg PO or IV (if unable to tolerate PO) times 1 dose
- Acetaminophen (Tylenol) 650 mg PO times 1 dose
- Other __________________________

**PRN Medication:**
- Diphenhydramine (Benadryl) 25 mg IV every 4 hours PRN itching or hives
- Acetaminophen (Tylenol) 650 mg PO every 4 hours PRN aches or temperature change greater than 1°C

LIMIT THE TOTAL DOSE OF ALL ACETAMINOPHEN CONTAINING PRODUCTS TO 3,000 MG PER DAY

**Infusion Directions:**
- Final concentration to be between 0.4 mg/ml and 4 mg/ml
- Do not shake
- Include 1.2 micron (or smaller) in-line filter
- Do not infuse other medication into the IV line with infliximab (Remicade). Flush with saline before and after medication administration.
- Infuse per the following infusion rate schedule or maximum tolerated by patient:

<table>
<thead>
<tr>
<th>Time (Minutes)</th>
<th>Infusion Rate Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Initiate therapy at 10/ml hour times 15 minutes</td>
</tr>
<tr>
<td>15</td>
<td>Increase to 20 ml/hour times 15 minutes</td>
</tr>
<tr>
<td>30</td>
<td>Increase to 40 ml/hour times 15 minutes</td>
</tr>
<tr>
<td>45</td>
<td>Increase to 80 ml/hour times 15 minutes</td>
</tr>
<tr>
<td>60</td>
<td>Increase to 150 ml/hour times 30 minutes</td>
</tr>
<tr>
<td>90</td>
<td>Increase to 250 ml/hour times 30 minutes</td>
</tr>
<tr>
<td>120</td>
<td>End of therapy</td>
</tr>
</tbody>
</table>

11. **VITAL SIGNS:**
- Obtain baseline vital signs. Monitor for signs and symptoms of drug reaction every 30 minutes, with vital signs. Obtain vital signs at completion of infusion and 30 minutes post infusion.
- Call physician if:
  - Systolic BP less than ______ mmHg
  - Pulse greater than __________
  - Temperature greater than ______ ° C

12. **DISCHARGE:**
- If stable 30 minutes post infusion, discharge patient home on current reconciled home medications

**NOTE:** These orders should be reviewed by the attending physician, appropriately modified for the individual patient, dated, timed and signed below.

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>PHYSICIAN’S SIGNATURE</th>
</tr>
</thead>
<tbody>
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Another brand of drug, identical in form and content, may be dispensed unless checked. ☐