St. Clair Hospital
Pittsburgh, PA 15243
Intravenous Infliximab
Physician Order Set

Name: _____ Date of Birth: _____

Allergies: _____ Weight: _____kg _____ lbs.

Diagnosis: _____

ICD-10 Code: _____ Insurance Info: _____

Ordering Physician Name (Print): _____

Administer: □ Infliximab-dyyb (Inflectra) IV (Formulary Product)

Non-formulary Products: (*to be given if preferred agent is per contract only)*:

□ Infliximab-axxq (Avsola) IV □ Infliximab-abda (Renflexis) □ Infliximab (Remicade)

Weight Based Dose: _____ (mg/kg) *(Dose will be rounded to the nearest 10mg)*

OR

Fixed Dose: _____(mg)

Frequency: Every_____ weeks

Rate: Will be administered at 125 mL/hr over 2 hr unless titration is selected

□ Titration requested (see box below):

Infusion Rate	Time (min)
10 mL/hr	For 15 minutes
20 mL/hr	For 15 minutes
40 mL/hr	For 15 minutes
80 mL/hr	For 15 minutes
150 mL/hr	For 30 minutes
250 mL/hr	Until end of therapy

Previous Reaction: □ Yes: *If yes, reaction symptoms:* _____ □ No

Medications to be given **30 minutes prior to start of infusion:**

□ Acetaminophen 650mg PO □ Methylprednisolone 40 mg IV push

□ Diphenhydramine 25 mg PO □ Fexofenadine 60 mg PO □ Other: _____

Assess for signs/symptoms of hypersensitivity and/or anaphylaxis:

- If signs/symptoms of reaction, administer diphenhydramine 25mg IV push (may repeat x1 in 15 minutes) **AND** Methylprednisolone 40mg IV push
- Ondansetron 4 mg IV push x1 for nausea

Also required from physician office:

- History and Physical, Assessment and Plan, or Physician Office Progress Note (s)
- Insurance authorization

Authorization # and Dates (*from and to)*: _____

Physician Office Phone: _____**Fax:** _____

(fax order and medical record documentation to 412-942-3559)

Physician Signature: _____Date: _____Time: _____