St. Clair Health

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-abda (Renflexis) IV** (Formulary Product)

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

☐ Infliximab-axxq (Avsola) IV ☐ Infliximab-dyyb (Inflectra) ☐ 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 chart below):

Infusion Rate	Time (min)	Infusion Rate	Time (min)
10 mL/hr	For 15 minutes	80 mL/hr	For 15 minutes
20 mL/hr	For 15 minutes	150 mL/hr	For 30 minutes
40 mL/hr	For 15 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:** __________

1123015KC