



Patient Name: _____
 DOB: _____
 Date of Last Infusion _____
 Insurance: _____

Clinic Location:
 Merrimack, NH
 Concord, NH

Infliximab-dyyb (Inflectra®) Infusion Orders

| | |
|--|---------------|
| Diagnosis (please provide ICD-10 code in space provided): | Weight: _____ |
| _____ Crohn's Disease _____ Ulcerative Colitis _____ Rheumatoid Arthritis _____ Psoriatic Arthritis _____ Ankylosing Spondylitis _____ Plaque Psoriasis | |
| TB screening status and date of result: _____ (please include copy of result with order) | |

Nursing:

- Hold infusion and notify provider:
 - Signs/symptoms of infection
 - Planned/recent surgical procedures
 - Recent live vaccines
 - Any concerning changes in health status
- If infusion-related reaction occurs, stop infusion, and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Dose: (may be rounded by up to 15% to nearest 100 mg)

Administer _____ mg/kg = _____ mg infliximab-dyyb in 250 mL 0.9% sodium chloride using an in-line, sterile, non-pyrogenic low-protein binding filter (pore size 1.2 micron or less). For doses exceeding 1000 mg, dilute in 500 ml 0.9% sodium chloride and adjust infusion rates accordingly

Pre-medications (to be administered once prior to infusion, no wait period required): PRN

- Tylenol 500 mg orally Zyrtec 10 mg orally Benadryl 25 mg orally

Other: _____

Frequency (chose one):

- On weeks 0, 2, and 6, then every _____ weeks Every _____ weeks

Titrate infusion rates as follows:

▪ **Initial three infusions:**

| Doses up to 1000mg | Doses exceeding 1000mg |
|---------------------------|---------------------------|
| 20 ml/hr x 15 minutes | 40mg/hr x 15 minutes |
| 80ml/hr x 15 minutes | 160mg/hr x 15 minutes |
| 150ml/hr x until complete | 300mg/hr x until complete |

- Monitor vital signs with every rate change and at least every 30 minutes.
- **All subsequent infusions (if previously well-tolerated):**
 - **Doses up to 1000mg-** Infuse at 125 ml/hr (over a period of *at least* 2 hours)
 - **Doses exceeding 1000mg-** Infuse at 250ml/hr (over a period of *at least* 2 hours)
 - Monitor vital signs every hour.

Provider name (print): _____ Date: _____

Provider signature: _____ Time: _____