Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

Infliximab-abda (Renflexis®) 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-abda 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: _________________

Revised 1/31/2020 (order valid for one year unless otherwise indicated)