SOMC Cancer Center & Infusion
Ph: (740) 356-7490
Fx: (740) 356-7488

Infliximab (Avsola, Inflectra, Remicade, Renflexis) Order Form

Once all of the requirements below have been completed and checked off, please call to schedule appointment at (740) 356-7492 and if non-SOMC provider fax all documents to (740) 356-7488. If you any questions or special needs, please discuss them at the time of scheduling. Thank you!

Name: , ______________________ **Date of Birth:** ______________
Phone Number: Home ______________ Cell ______________ **Weight:** __________
Allergies: ______________________________
Diagnosis:
☐ Primary Diagnosis ______________________________

Infliximab Infusion Policy Prior Treatment Requirements:
- ☐ Scheduled Treatment Date: ______________
- ☐ H & P or progress note within last 30 days prior to initiating treatment

Order: ☐ **Remicade** _______ mg/kg ☐ **Renflexis** _________ mg/kg ☐ **Inflectra** _________ mg/kg
with ☑ 0.9% NS 250 mL primary at KVO during infusion
Every ______________________ for ________ treatments
(schedule) (total treatments)
Amount given ________ mg Amount wasted _______ mg

Remicade Infusion Table - Infuse over 2 hours

Time (min)	Rate (ml/hr)
0	10
15	20
30	40
45	80

Time (min)	Rate (ml/hr)
60	150
90	250
120	end of infusion

Pre-Treatment Medications:
- ☐ Tylenol (acetaminophen) 650mg by mouth x 1 dose prior to treatment
- ☐ Benadryl (diphenhydrAMINE) 25mg by mouth x 1 dose prior to treatment
- ☐ Benadryl (diphenhydramine) 25mg IVP x 1 dose prior to treatment
- ☐ Claritin 10mg po x 1
- ☐ Hydrocortisone 100mg IVP x 1 dose prior to treatment
- ☐ O2 at ______ liters/min via ____ NC ___ Oxymask (titrate at above 94%)
- ☐ Other ______________________________

Adverse Reaction:
- ☐ Benadryl 25 mg IV push x 1 for rash, hives or itching
- ☐ Solumedrol 125 mg push x 1 for rash, hives or itching
- ☐ Epinephrine (1:1000) 0.3 mg (0.3 mL) IM x 1 for Respiratory distress
- ☐ O2 per oxymask to maintain O2 saturation above 94%
- ☐ Give all of the above medications for an anaphlyactic reaction as evidenced by swelling of tongue, lips, and throat, trouble breathing, wheezing, abdominal pain, vomiting, dizziness, rash, hives, itching
- ☐ Anaphylaxis - stop infusion immediately, maintain IV patency with Normal Saline, notify ordering provider, and prepare to transfer to Emergency Department.

Labs: ______________________________

Provider Signature:

DATE:	TIME:	SIGNATURE:

Printed Provider Name: ______________________________
Phone number of referring provider: **Phone #** ______________________
Fax number of referring provider: **Fax #** ______________________

Reviewed & Approved, J. Janney, RPh, PharmD 6/29/2016

Southern Ohio Medical Center

remi
Rev. J. Janney/Order Set Team 07/22/2020
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DOB: