INFUSION SUITE		INFLIXIMAB INFUSION ORDERS	
406 Arthritis Clinic LLC		Phone: 406-345-0211	Fax: 747-205-0742
2409 Arnold Ln Ste 9 Billings, MT 59102			
PATIENT INFORMATION - Include Patient Demographics and Insurance Cards			
Name:		DOB:	
	MEDICAL INFORMATION		
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
	REQUIRED TESTING		
☐ TB: ___________ ☐ Hepatitis B:_______________ *Both required annually			
Additional labs:			
☐ Insert IV	☐ Access Port/PICC		
	PREMEDICATIONS 30 minutes prior to starting		
☐ Acetaminophen:	☐ 325mg PO X1 ☐ 500mg PO X1 ☐ 650mg PO X1		
☐ Diphenhydramine:	☐ 25mg IVP X1 ☐ 25mg PO X1 ☐ 50mg IVP X1 ☐ 50mg PO X1		
☐ Solumedrol:	☐ 40mg IV X1 ☐ 100mg IV X1 ☐ 125mg IV X1		
☐ Antihistamine:	☐ Cetirizine 10mg PO X1 ☐ Loratadine 10mg PO X1		
☐ Additional PRN:			
☐ Biosimilar substitute allowed for insurance mandates			
	REMICADE ORDERS		
☐ Initial:	______mg/kg IV on Week 0, Week 2, Week 6 **OR** _____________ mg on Week 0, Week 2, Week 6		
☐ Maintenance:	______mg/kg IV every _______ weeks X ________ **OR** ________ mg every ______ weeks X ______		
	RENFLEXIS ORDERS		
☐ Renflexis:	______mg/kg IV on Week 0, Week 2, Week 6 **OR** _____________ mg on Week 0, Week 2, Week 6		
☐ Frequency:	______mg/kg IV every _______ weeks X ________ **OR** ________ mg every ______ weeks X ______		
	INFLECTRA ORDERS		
☐ Inflectra	______mg/kg IV on Week 0, Week 2, Week 6 **OR** _____________ mg on Week 0, Week 2, Week 6		
☐ Frequency:	______mg/kg IV every _______ weeks X ________ **OR** ________ mg every ______ weeks X ______		
	AVSOLA ORDERS		
☐ Avsola:	______mg/kg IV on Week 0, Week 2, Week 6 **OR** _____________ mg on Week 0, Week 2, Week 6		
☐ Frequency:	______mg/kg IV every _______ weeks X ________ **OR** ________ mg every ______ weeks X ______		
	OTHER: ________________		
☐			
☐			
	POST INFUSION		
☐ Flush IV line with NS. D/C IV.			
☐ Flush port with 5-10mL 0.9% NS. Lock port with Heparin 10u/mL IVP (based of size port). De-access port.			
☐ Discharge home			
Referring Provider Printed:			
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
406 **Provider Printed:**			
406 Provider Signature:		Date:	

Credentials must be included

**Vital Signs should be monitored with every rate change*

Infusion Directions:

- Remove vials and allow to come to room temp before administration
- Reconstitute each vial with 10mL Sterile Water for Injection using syringe and 21G needle or smaller
- Direct the stream of Sterile Water to the wall of the vial to avoid foaming.
- Gently swirl to dissolve the lyophilized powder, do not shake, allow to stand for 5 minutes
- Obtain a 250mL bag of NS, withdraw NS equal to the volume of the infliximab dose from the NS bag
- Withdraw the dose of infliximab from the vial(s) and add slowly into the NS bag, gently invert to mix
- Discard and document any drug waste
- Infuse over 2 hours (minimum) with a low protein binding 1.2micron or less, in-line filter tubing
- Follow titration infusion rate chart below:

Infliximab 250mL infusion rates	Infliximab 500mL Infusion rates (Over 1000mg)
10mL/hour x 15 minutes / 3mL	20mL/hour x 15 minutes / 5 mL
20mL/hour x 15 minutes / 5 mL	40mL/hour x 15 minutes / 10mL
40mL/hour x 15 minutes / 10mL	80mL/hour x 15 minutes / 20mL
80mL/hour x 15 minutes / 20mL	160mL/hour x 15 minutes / 40 mL
150mL/hour x 30 minutes / 75 mL	300mL/hour x 30 minutes / 150mL
250mL/hour x 33 minutes / 137 mL	500mL/hour x 33 minutes / 275 mL

Infliximab Dose Calculator: https://www.remicadehcp.com/index.html