MUNSON HEALTHCARE

Form 12565 (09/22)

AUTHORIZATION IS GRANTED TO DISPENSE AND ADMINISTER AN ALTERNATE DRUG PRODUCT ACCEPTABLE TO THE MEDICAL STAFF'S PHARMACY COMMITTEE UNLESS THE DRUG PRODUCT IS SPECIFICALLY CIRCLED.

□ LOADING dose at 0, 2, and 6 weeks	Estimated treatment initiation date:	Allergies/Reactions:

Diagnosis (Complete One Box Below)

□ Treatment of **moderately to severely active Crohn's disease** (ICD 10 Code _____) (to reduce signs/symptoms and induce and maintain clinical remission) or to reduce the number of draining enterocutaneous and rectovaginal fistulas and maintain fistula closure **PLUS** (must complete below)

□ A. Previous inadequate response to conventional therapy

Drug Failed:

Treatment Dates: From (mm/yy) _____ to (mm/yy)_____.

Reason for Failure:

□ Treatment of **moderately to severely active ulcerative colitis** (ICD 10 Code _____) (to reduce signs/symptoms and induce and maintain clinical remission) or to induce/maintain mucosal healing and eliminate corticosteroid use in adults **PLUS** (must complete below)

□ A. Previous inadequate response to conventional therapy

Drug Failed:

Treatment Dates: From (mm/yy)_____ to (mm/yy)_____.

Reason for Failure:

□ Treatment of **moderately to severely active rheumatoid arthritis** (ICD 10 Code _____) (to reduce signs/symptoms of active arthritis and inhibit progression of structural damage and improve physical function) **PLUS** (must complete below)

□ A. On concurrent methotrexate therapy

□ Treatment of **active ankylosing spondylitis (**to reduce signs/symptoms)
(ICD 10 Code _____)

□ Treatment of **psoriatic arthritis** (to reduce signs/symptoms of active arthritis and inhibit progression of structural damage and improve physical function)
(ICD 10 Code _____)

□ Treatment of **chronic, severe (extensive and/or disabling) plaque psoriasis** as an alternative to other systemic therapy
(ICD 10 Code _____)

Lab orders: CBC with differential and CMP per provider (provide separate order)

Tuberculin Screening complete on (Date): _____
Results: _____

Hepatitis B Screening complete on (Date): _____
Results: _____

Weight: _____kg

(Weigh patient prior to each dose, notify provider for fluctuations > 10%)

HOLD treatment & notify provider if:
- Fever or evidence of infection
- LFTs > 5 x ULN

Emetic Risk: Minimal
Monitor:
- For infection
- For infusion related reactions
- Liver function

REMS: Medication Guide provided with each treatment

SAFETY LINE

0.9% NaCl (gravity flow). Use as free-flow for IV push doses (if applicable) and post chemotherapy line flush.

TREATMENT	DOSAGE	ADMINISTRATION INSTRUCTIONS	FREQUENCY
Choose one: **Preferred:** □ **InFLIXimab-abda** (Renflexis) **Alternative:** □ Infliximab-dyyb (Inflectra) □ Infliximab (Remicade-generic) **Reason for selecting alternative:** □ Insurance requirements, including enrollment in patient assistance program □ Intolerance □ **Unless checked,** pharmacy may select alternative biosimilar agent IF preferred by patient's insurance	**_____mg/kg = _____ mg** *Dose rounded to the nearest 100mg*	In 0.9% NaCl 250 mL over at least 2 hours Use in-line low protein binding filter (≤1.2 micron) *Infusion should begin within 3 hours of preparation*	x 1 dose per loading dose schedule above

IF PATIENT HAS A HYPERSENSITIVITY REACTION, BEGIN HYPERSENSITIVITY PROTOCOL, Policy 061.060

Patient Name:

Date of Birth:

The provider's full signature(s) is to follow the order

Provider Signature **Date** **Time**

Provider Printed Name

InFLIXimab LOADING Dose

SYMPTOM MANAGEMENT			
DRUG	**DOSE**	**ADMINISTRATION INSTRUCTIONS**	**FREQUENCY**
□ Acetaminophen	650 mg	Oral	x 1 dose if needed for headache during infusion
□ DiphenhydrAMINE	25mg	IV Push over 1 minute	x 1 dose if needed for itching/rash during infusion

ADDITIONAL ORDERS

For symptomatic hypotension, slow infusion rate. If no improvement, stop infusion, bolus with 125-250 mL 0.9% NaCl and notify provider.

Discontinue IV upon completion of treatment, flush order per protocol

NURSING INSTRUCTIONS

For InFLIXimab:

1. Monitor vital signs at baseline and every 30 minutes for the first hour or until stable, then every 60 minutes until completion of inFLIXimab infusion.

Pulse oximetry PRN dyspnea.

Reference: Arthritis Care Res (Hoboken)2012,64(5):625-39., Arthritis Rheum 2005,52(2):548-53
Am J Gastroenterol 2010, 105(3):501-23; Am J Gastroenterol 2009, 104(2): 465-83; Gastroenterology 2013,145(6):1459-1463

Patient Name:

Date of Birth:

The provider's full signature(s) is to follow the order

Provider Signature **Date** **Time**

Provider Printed Name

InFLIXimab LOADING Dose