Lake Charles Memorial Health System

1PO

PO_Infliximab
Order Set
Last Revised: 03/06/2023

InFLIXimab Order Set:
Patient Name: _____ DOB: _____
Height: _____ Weight: _____(kg) Allergies: _____

Assign as Outpatient
Administration: A negative TB skin test or other appropriate documentation of TB status must be faxed to 430-6976 prior to scheduling of appointment for patient.
Diagnosis:
___ M06.___ Rheumatoid Arthritis ___ L40.9 Psoriasis ___ M45.___ Ankylosing Spondylitis
___ K50.___ Crohn's Disease ___ K51.___ Ulcerative Colitis ___ Other (ICD-10 Code): _____
Labs
____**To be completed UPON TO ARRIVAL in infusion center:**
____ CBC with differential: ____ Prior to every infusion ____ Every 3 months
____ Every 4 weeks x 3 months then every 3 months thereafter
____ CMP: ____ Prior to every infusion ____ Every 3 months
____ Lipid panel with 2nd infusion and then every 6 months (fasting)
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Upon arrival to infusion center:

- ____Check current labs, call MD for ANC < 2000, platelets < 100,000/mm3 for possible interruption of therapy or dosage adjustment
- Screen patients for any active infections prior to administration, if any signs or symptoms of infection present hold and call MD

Premedication: Give 15 minutes prior to infusion
___ Acetaminophen 650 mg PO x 1 dose ___ methylPREDNISolone 125 mg IV x 1 dose
___ diphenhydrAMINE 25 mg PO x 1 dose ___ diphenhydrAMINE 25 mg IV x 1 dose
___ diphenhydrAMINE 50 mg PO x 1 dose ___ diphenhydrAMINE 50 mg IV x 1 dose
___ Other: _____

infliximab :

- **infliximab-axxq (Avsola) – Choose from the following:**
  ____ Administer _____ mg/kg IV on day 0, 2 weeks, 6 weeks, and then every _____ weeks.
  ____ Administer _____ mg/kg IV every _____ weeks. Duration _____
  All doses to be administered in 250 mL of Normal Saline. Infuse over at least 2 hours. Doses may be rounded to the nearest vial size (no greater than 10% change). Maximum dose = 10 mg/kg

IV Line Care:

- Normal Saline 10 ml IV flush after each use
- For implanted ports: Heparin 100 units/ml 5 ml IV flush after each use or prior to deaccessing

Discharge when infusion complete

Other Instructions:

- *New MD order required every 6 months unless defined in original order*
- If preferred infliximab product is NOT covered by insurance or insurance requires approval under the pharmacy benefit plan, contact pharmacy at 337-494-4161.

Physician Signature: _____ Date/Time:_____