

Place patient identification sticker here

**DOCTOR'S ORDER SHEET –
REMICADE/INFLECTRA INFUSION**

Allergies: NKA

******UNAPPROVED ABBREVIATIONS******

QD, QOD, MgSO₄, MSO₄, MS, IU, U or -u, ug, Use of a Trailing Zero (X.0mg), Lack of a Leading Zero(Xmg)

DATE	TIME	ORDERS	NURSE SIGNATURE
		Assign to outpatient status	
		Diagnosis:	
		VS: Q 15 minutes x 4, then q 30 minutes x 2	
		IV: 0.9 NS at KVO	
		Regular Diet	
		<input type="checkbox"/> Dexamethasone 20mg IV once 30 minutes prior to infusion	
		<input type="checkbox"/> Benadryl _____ mg IV x 1 dose 30 min prior to infusion	
		<input type="checkbox"/> Benadryl _____ mg PO x 1 dose 30 min prior to infusion	
		Acetaminophen 650 mg po x 1 dose 30 min prior to infusion	
		<input type="checkbox"/> Inflectra (Infliximab – dyyb biosimilar)	
		<input type="checkbox"/> Remicade (Infliximab) *BRAND REQUIRED*	
		Dose of _____ mg/kg X _____ kg total dose of _____ mg	
		Mix in 250 cc NS (more than 10 vials will require more than 250 ml NS to achieve proper concentration of 0.4 – 4 mg/ml) and run through a 1.2 mm or less low protein binding filter using the following infusion rate for doses 1-4:	
		10 ml/hr x 15 minutes 20 ml/hr x 15 minutes 50 ml/hr x 15 minutes 120 ml/hr x 15 minutes 150 ml/hr x 30 minutes 250 ml/hr x 30 minutes	<u>For patients without a history of infusion reaction:</u> After dose 4, run using the following infusion rate (only for doses equal to or less than 1000 mg): - 100 ml/hr x 15 min - 300 ml/hr x until the infusion is complete
		If suspected reaction: 1. Stop Infusion 2. Continue normal saline KVO 3. Notify physician	If dose is >1000 mg continue using 2 hr infusion time
		Above orders may repeat every _____ week(s) for 6 months	
		Nursing will notify Pharmacy of dose number and any history of infusion reactions to doses #1-4	

USE BALL POINT PEN FAX TO PHARMACY

Qualified Medical Provider signature

Date

Time

