Samaritan Medical Center
Watertown, NY

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DOCTOR'S ORDER SHEET – REMICADE/INFLECTRA INFUSION

Allergies: ☐ **NKA**

******UNAPPROVED ABBREVIATIONS******
QD, QOD, $MgSO_4$, MSO_4, 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	
		☐ Dexamethasone 20mg IV once 30 minutes prior to infusion	
		☐ Benadryl _____ mg IV x 1 dose 30 min prior to infusion	
		☐ Benadryl _____ mg PO x 1 dose 30 min prior to infusion	
		Acetaminophen 650 mg po x 1 dose 30 min prior to infusion	
		☐ Inflectra (Infliximab – dyyb biosimilar)	
		☐ 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 _____

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INFORMED CONSENT FOR TREATMENT – REMICADE / INFLECTRA

Your doctor has ordered a special medication called Remicade/Inflectra which is given through your veins for the treatment of _____. Remicade/Inflectra blocks the activity of an inflammatory agent called tissue necrosis factor (TNF). TNF is a cause of inflammation. Too much TNF may cause some diseases associated with inflammation such as Rheumatoid Arthritis. Remicade/Inflectra is known as an "anti-TNF agent" and blocks TNF and reduces the signs and symptoms in patients with moderate to severe active disease.

I understand the risks of treatment with Remicade/Inflectra to include: hives, difficulty breathing, low blood pressure, fever, rash, headache, sore throat, muscle aches, joint pain, hand and facial swelling and/or difficulty swallowing. In very rare cases an anaphylactic reaction (severe allergic reaction) may occur. You may also be at risk for severe infections. These side effects can occur during or after your infusion. There may be worsening of multiple sclerosis or heart failure symptoms.

I understand the benefits of treatment with Remicade/Inflectra to include: improved symptoms for the disease for which I am being treated.

I understand the alternative to treatment with Remicade/Inflectra: as explained to me by my provider. In addition, I understand that my care requires the use of an intravenous catheter (tube). I also realize that a catheter inserted in my arm has certain risk such as: phlebitis, bleeding at the site, and infection. Appropriate measures will be taken to minimize these complications.

Medication Administration:

- Remicade/Inflectra is administered through your vein over one (1) to three (3) hours. Sometimes it may be necessary to slow down the infusion and administer Remicade/Inflectra over a longer time. A clinician will monitor you closely while receiving Remicade/Inflectra.
- You will see your physician one or two weeks before each infusion to determine how you are responding to Remicade/Inflectra and to adjust your therapy accordingly. You may also contact your physician's office if you have any questions regarding how you are feeling.
- Sometimes patients will need to take medications before receiving Remicade/Inflectra to reduce the risk of side effects.
- Should the need arise during my treatment, I agree to the use of any emergency procedures deemed necessary by the supervising physician.

I certify that I have:

- Read and fully understand the above consent for treatment with Remicade/Inflectra and
- Received explanation of the risks, benefits, and alternatives of Remicade/Inflectra.
- I acknowledge that no guarantees or assurances have been made to me concerning the results intended from taking the medication.
- I have been given the opportunity to ask questions and to speak to my ordering physician. I authorize the administration of Remicade/Inflectra.

The consent for Remicade/Inflectra is valid for six (6) months from the date of signature and is valid for multiple infusions.

_____ Patient Signature _____ Date _____ Time

_____ Witness to Signature _____ Date _____ Time

The signature of the patient must be obtained unless the patient is a minor, unable to give consent, or otherwise lacks capacity.

_____ Signature of Person Authorized to Consent for the Patient _____ Date _____ Time

_____ Relationship to the Patient

_____ Witness to Signature _____ Date _____ Time

I hereby certify that I have explained the nature, purpose, benefits, risks, of, and alternatives to (including no treatment) the proposed administration of Remicade/Inflectra. I have offered to answer any questions and have fully answered all such questions. I believe the patient/relative/guardian fully understands what I have explained and answered.

_____ Physician Signature _____ Date _____ Time