Samaritan Medical Center
Watertown, NY

Place patient identification sticker here

DOCTOR'S ORDER SHEET – PHARMACY – INFLIXIMAB INFUSION

Diagnosis:

Allergies: ☐ **NKA**

Height _____ **Weight** _____ **kg**

******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	
		VS: Q 15 minutes x 4, then q 30 minutes x 2	
		IV: 0.9 NS at KVO	
		Regular Diet	
		PRE-MEDICATIONS:	
		☐ 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	
		MEDICATION:	
		☐ Avsola (infliximab-axxq)	
		☐ Inflectra (infliximab-dyyb)	
		☐ Ixifi (infliximab-qbtx)	
		☐ Remicade (infliximab)	
		☐ Renflexis (infliximab-abda)	
		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* *3.) Administer PRN medications per infusion reaction medication ordered;* *4.) Call Max Cart;* *5.) Notify MD*	
		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 _____