LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order INFLIXIMAB-dyyb (INFLECTRA) & INFLIXIMAB (REMICADE)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

Anticipated Start Date: _____ **Patient to follow up with provider on date:** _____
*****This plan will expire after 365 days, unless otherwise specified below*****
Orders expire: _____

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis: _____ **Diagnosis Code:** _____

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.**
2. A Tuberculin test (PPD) or QuantiFERON Gold must have been read as negative within the past year. If the QuantiFERON Gold is indeterminate a CHEST X-ray should be performed to rule out infection
3. Hepatitis B (Hep B surface antigen AND core antibody) screening must be completed prior to initiation of therapy and the patient should not be infected
4. Patient should not have an active ongoing infection, signs or symptoms of malignancy, or moderate to severe heart failure at the onset of infliximab-dyyb therapy. Baseline liver function tests should be normal
5. Patients should have regular monitoring for TB, Hepatitis B, infection, malignancy, and liver abnormalities throughout therapy

PRE-SCREENING: (Results must be available prior to initiation of therapy)

- Hepatitis B Surface AG Result Date: _____ ☐ Positive / ☐ Negative
- Hepatitis B Core AB Qual, Result Date: _____ ☐ Positive / ☐ Negative
- Tuberculin Test Result Date: _____ ☐ Positive / ☐ Negative
- QuantiFERON Gold Test Result Date: _____ ☐ Positive / ☐ Negative
- Chest X-ray (if QuantiFERON Gold indeterminate) Result Date: _____ ☐ Positive / ☐ Negative
- Baseline CMP/LFT Result Date: _____ ☐ WNL / ☐ Negative

LABS TO BE DRAWN (orders must be placed in TVC EPIC by ordering provider if TVC provider):

☐ Complete Metabolic Panel, Routine, ONCE, every _____(visit)(days)(weeks)(months)- **Circle one**
☐ CBC with differential, Routine, ONCE, every _____(visit)(days)(weeks)(months)- **Circle one**
☐ Other: _____

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PRE-MEDICATIONS:

- ☐ Acetaminophen (TYLENOL) tablet, oral, ONCE, every visit
  - ☐ 650 mg
  - ☐ 325 mg
  - ☐ Other: _____
- ☐ Diphenhydramine (BENADRYL) tablet, oral, ONCE, every visit
  - ☐ 25 mg
  - ☐ 50 mg
- ☐ Cetirizine (ZYRTEC) tablet, oral, ONCE, every visit ***(Choose as alternative to diphenhydramine if needed)***
  - ☐ 10 mg
- ☐ Methylprednisolone sodium succinate (SOLU-MEDROL) IV, ONCE, every visit ***(Choose if patient has required IV steroids for a reaction during prior TNF-alpha inhibitor infusion)***
  - ☐ 62.5 mg
  - ☐ Other: _____

MEDICATIONS: (must check one):

Biosimilar selection (must check one) – applies to all orders below

- ☐ INFLECTRA (inFLIXimab-dyyb) ****formulary agent****
- ☐ *REMICADE (inFLIXimab) *Restricted ONLY to existing REMICADE patients for continuing therapy, or patients whose insurance will only cover REMICADE*

Dose: (Pharmacist will use most recent weight and round dose to the nearest 100 mg vial – dose selected at initiation will be continued, unless new orders are received specifying a dose modification)

Administer through an in-line low protein binding filter (less than or equal to 1.2 micron). Titrate per Legacy protocol 900.4069. Doses greater than 1000mg to be mixed in 500mL NaCl 0.9%.

- ☐ 3 mg/kg in NaCl 0.9% IV, ONCE, every visit
- ☐ 5 mg/kg in NaCl 0.9% IV, ONCE, every visit
- ☐ 10 mg/kg in NaCl 0.9% IV, ONCE, every visit
- ☐ _____ mg/kg in NaCl 0.9% IV, ONCE, every visit
- ☐ _____ mg in NaCl 0.9% IV, ONCE, every visit

Interval:

- ☐ Once
- ☐ Three doses at Week 0, 2, and 6, then every _____ weeks
- ☐ Other: _____

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☐ Every _____ weeks for _____doses

AS NEEDED MEDICATIONS:

- Acetaminophen 650 mg oral, EVERY 4 HOURS AS NEEDED for hypersensitivity or infusion reaction, chills, or malaise
- Diphenhydramine 25 mg oral, may repeat x 1 EVERY 4 HOURS AS NEEDED for itching
- NaCl 0.9% 500 mL IV, AS NEEDED, ONCE, infusion tolerability. Give concurrently with infliximab/infliximab-dyyb

NURSING ORDERS (TREATMENT PARAMETERS):

1. Vital signs, every visit: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion, at each rate increase and at the end of infusion per Legacy protocol 900.4069
2. Nursing communication order, every visit: Infuse over at least 1 hour, titrated per Legacy protocol 900.4069
3. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
4. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606

HYPERSENSITIVITY MEDICATIONS: Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients

1. Hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
2. Diphenhydramine 25-50 mg IV, EVERY 2 HOURS AS NEEDED for hypersensitivity reaction (Max dose: 50 mg)
3. Famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. Epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. Naloxone (Narcan) 0.4 mg IV, AS NEEDED x1 dose for diminished respiratory rate
6. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction

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Please check the appropriate box for the patient's preferred clinic location:

☐ **Legacy Day Treatment Unit**
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Salmon Creek Day Treatment Unit**
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

☐ **Legacy Emanuel Day Treatment Unit**
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Organization/Department: _____