LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

INFLIXIMAB AND BIOSIMILARS

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

ORDERING GUIDELINES:

☒ Send **FACE SHEET and H&P or most recent chart note**

☒ **INDUCTION:**

- Screen for viral hepatitis (Hep B and Hep C) and HIV prior to use.
- PRIOR to initiation of treatment, ensure baseline labs CMP, CBC with diff and liver function tests are done and baseline PPD or quantiFERON Gold blood tests are negative.
- Patient should not have an active ongoing infection, signs or symptoms of malignancy, or moderate to severe heart failure at the onset of TNF-alpha inhibitor therapy.
- Patient should have regular monitoring for TB, hepatitis B, infection, malignancy, and liver abnormalities throughout therapy.

☒ **MAINTENANCE:**

- Patient should not have an active ongoing infection, signs or symptoms of malignancy, or moderate to severe heart failure at the onset of TNF-alpha inhibitor therapy.
- Patient should have regular monitoring for TB, hepatitis B, infection, malignancy, and liver abnormalities throughout therapy.

MEDICATIONS:

☒ BIOSIMILAR **infliximab-abda** *(RENFLEXIS)* is the preferred formulary agent. Other biosimilars may be used based on insurance coverage. Brand name REMICADE is no longer available. For the generic version of infliximab, indicate reason for not selecting the preferred biosimilar.

☒ **Select ONE Product:**

☐ **PREFERRED: infliximab-abda** *(RENFLEXIS)* in **0.9% sodium chloride** IV

☐ Alternative: **infliximab-dyyb** *(INFLECTRA)* in **0.9% sodium chloride** IV

☐ NON-PREFERRED: **infliximab** (generic for *REMICADE*) in **0.9% sodium chloride** IV **X** 1

NOTE reason for not selecting preferred products **(required)**: _____

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Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

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☒ **Select Dose/Interval:**

☐ Induction + Maintenance:

☐ _____ mg/Kg (= _____ mg) at Weeks 0, 2, and 6

Then followed by _____ mg/Kg (=_____ mg) every _____ weeks thereafter.

Other:_____

☐ Maintenance Only:

☐ _____ mg/Kg (=_____ mg) every _____ weeks

☒ **Infusion Rate:** Infuse over at least 2 hours. Use in-line low protein binding filter (**less than/equal to** 1.2 micron). For previous infusion reactions, all subsequent infusions begin at 10 mL/hour for 15 minutes, then double the rate Q15 minutes up to a maximum of 125 mL/hour.

PRE-MEDICATIONS – *If ordered, administer 30 to 60 minutes prior to infusion***.**
{Choose One:}

☐ DO NOT give any pre-medications.
☐ Give pre-medications with each infusion.
☐ Give pre-medications with each infusion if patient has a history of infusion reaction.

- **acetaminophen** *(TYLENOL)* 650 mg tablet PO PRN **x** 1 dose.
- **diphenhydrAMINE** *(BENDADRYL)* 25 mg tablet/capsule PO PRN **x** 1 dose. May give loratadine if patient driving or causes excessive drowsiness. Give loratadine or diphenhydramine, not both.
- **diphenhydrAMINE** *(BENADRYL)* 25 mg IV PRN **x 1** dose if patient cannot tolerate PO. May give loratadine if patient driving or causes excessive drowsiness. Give either loratadine or diphenhydramine, not both.
- **loratadine** *(CLARITIN)* 10 mg tablet PO PRN **x** 1 dose May give loratadine if patient driving or causes excessive drowsiness. Give either loratadine or diphenhydramine, not both.
- **methylPREDNISolone sodium succinate** *(SOLU-MEDROL)* injection 40 mg IV **x** 1 dose. Administer prior to infusion over 5 minutes.

TREATMENT PARAMETERS:

☒ Do **not** administer **infliximab** (including biosimilars) and notify Provider if patient has:

- temperature **greater than** 100.4°F
- complains of symptoms of acute viral or bacterial illness, or
- if patient is taking antibiotics for current infection.

HYDRATION / MAINTENANCE TKO:

☒ **0.9% sodium chloride** 25 mL/hour IV **x** 1 PRN flush/hydration/main bag/TKO

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LINE CARE MAINTENANCE:

- ☒ Follow facility policies/procedures for all vascular access maintenance with appropriate flush solutions, de-clotting (Alteplase), and/or dressing changes
- ☒ **alteplase** *(CATHFLO ACTIVASE)* injection 2 mg/2 mL intra-catheter **x** 1 PRN de-clotting **x** 2 doses
- ☒ **heparin, porcine - Preservative Free (PF)** 100 units/mL IV syringe 500 units intra-catheter **x** 1 PRN line care
- ☒ **0.9% sodium chloride** 10 mL IV flush PRN as needed
- ☒ If applicable, may remove PICC line at the completion of course of therapy

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

** *Itching, hives, fever* **

- ☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
- ☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction
- ☒ VS Q15 minutes **x** 4 and PRN
- ☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.
- ☒ **diphenhydramine** *(BENADRYL)* 25 MG IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose. May repeat **x** 1 ***{Maximum dose = 50 mg}***
- ☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
- ☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION

** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* **

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

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