



Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### Remicade® (infliximab) Infusion Orders

**Diagnosis (please provide ICD-10 code in space provided):**

_____ Rheumatoid Arthritis (ICD-10)	_____ Ankylosing Spondylitis (ICD-10)
_____ Psoriatic Arthritis (ICD-10)	_____ Other: _____ (ICD-10) (description)

**Nursing Orders:**

- Hold infusion and notify provider for:
  - Signs/symptoms of illness or active infection
  - Planned/recent surgical procedures
  - Recent live vaccinations
- Measure and record weight at each appointment
- If infusion-related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

**Premedications:**

Tylenol 500 mg PO PRN   
  Loratadine 10 mg PO PRN   
  Solu-Medrol 125 mg IVP  
 Benadryl 25 mg PO PRN   
  Other: \_\_\_\_\_

**Lab Orders:**

CBC w/diff, CMP, ESR, CRP every other infusion  
 Quantiferon TB Gold once per year; target collection date: \_\_\_\_\_  
 Other: \_\_\_\_\_

Administer infliximab \_\_\_\_\_ mg/kg x current weight ( \_\_\_\_\_ kg) = \_\_\_\_\_ mg in 250 mL 0.9% sodium chloride. Use in-line, sterile, non-pyrogenic low-protein binding filter (pore size 1.2 micron or less).  
 For doses exceeding 1000 mg, dilute in 500 ml 0.9% sodium chloride.  
 Dose may be rounded by up to 15% to nearest 100 mg per protocol. To PROHIBIT dose rounding, check here (  ).  
 May substitute biosimilar (infliximab-dyyb or infliximab-abda) if required by payor; If BRAND NAME MEDICALLY NECESSARY check here (  ) to prohibit biosimilar substitution.

**Titrate infusion rates as follows (rates calculated for 250 ml volume infusions):**

- **Initial three infusions:**
  - Start infusion at 20 ml/hr for 15 minutes, then increase to 80 ml/hr for 15 minutes.
  - May increase as tolerated to max rate of 150 ml/hr for remainder of infusion.
  - Monitor vital signs with every rate change and at least every 30 minutes.
- **All subsequent infusions (if previously well-tolerated):**
  - Infuse at 125 ml/hr (over a period of at least 2 hours).
  - Monitor vital signs every hour.

**Frequency (chose one):**

Weeks 0, 2, and 6, then every \_\_\_\_\_ weeks                     
  Every \_\_\_\_\_ weeks

Provider (please print): \_\_\_\_\_

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_