MHS Home/Alternate Site Infusion Services
Infliximab or Biosimilar Infusion Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name:	**DOB:** _____/_____/_____	**Weight:** _____ lb/kg
Patient Phone Number: (_____) _____-_____	**Requested Date of Service:** _____/_____/_____	

Patient Allergies:

Diagnosis: _____ **ICD – 10 Code:** _____

- Z45.2: Encounter for adjustment and management of vascular access device
- Z95.828: Presence of other vascular implants and grafts

Baseline Labs Required:

- Latent TB testing/Quantiferon: Date: _____/_____/_____ Result: _____
- CBC and CMP Date: _____/_____/_____ Result: _____
- HBV screening Date: _____/_____/_____ Result: _____
- HCV screening Date: _____/_____/_____ Result: _____
- HIV screening Date: _____/_____/_____ Result: _____

Maintenance Labs Required:

- Latent TB testing every 12 months
- CBC and CMP every 12 months

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider _____ (required) ****

Provider Order for Infliximab or Biosimilar Infusion

ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Pre-Medication(s): *Select all that apply*:

- □ None
- □ Acetaminophen: 650 mg tab/cap by mouth once, 30 minutes prior to infusion *(patient may provide own supply)*
- □ Diphenhydramine: 25 mg tab/cap by mouth once, 30 minutes prior to infusion *(patient may provide own supply)* **OR**
- □ Loratadine: 10 mg tab/cap by mouth once, 30 minutes prior to infusion *(patient may provide own supply)*
- □ Other: _____

Biologic Infusion:

Infliximab or Biosimilar *(pharmacy will dispense MultiCare or insurance preferred product)*
Weight: _____kg
Dose: Infuse _____mg/kg = _____mg *(round to nearest 100 mg)* IV in appropriate volume of NaCl 0.9% IV (final concentration 0.4-4 mg/mL), over at least 2 hours via infusion pump using 1.2 micron *(or smaller)* in-line filter.

Once the patient has been established on treatment without serious infusion reaction, infusion time will be shortened to 1 hour for patients with doses less than or equal to 6 mg/kg: □ Yes □ No

Frequency: Infusion frequency may vary **+/-5 days** from infusion due date.

Initiation: □ At weeks 0, 2, and 6; then every 8 weeks

Maintenance: □ Every 4 weeks □ Every 6 weeks □ Every 8 weeks □ Other: _____

Additional Medications for vascular access maintenance:

- 0.9% NaCl (NS) PF flush in 10 mL syringe: Administer 5 – 30 mL IV as needed for establishing and maintaining IV access and for flushing IV line post infusion.
- Heparin: 100 units/mL for port OR 10 units/mL for other central line/midline, 3-5 mL PRN for de-accessing line.
- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion.

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Skilled Nurse to draw labs as follows:

- □ CBC w/ diff and CMP every 12 months Or other frequency: _____
- □ Latent TB testing (*Quantiferon*) every 12 months Or other frequency: _____
- □ Other Lab(s): _____ Frequency: _____

Skilled Nurse Interventions:

- Admit *(first visit)* patient to services for home infusion therapy of Infliximab or Biosimilar.
- Complete Skilled Nurse visit with each infusion for ongoing home infusion therapy of Infliximab or Biosimilar.
- Obtain vital signs (TPR & B/P) at baseline and at completion of infusion.
- Obtain patient weight at each visit.
- Establish IV access and flush per policy to maintain patency.
- Draw labs as ordered.
- Administer pre-medications as prescribed.
- Reconstitute each vial of Infliximab or Biosimilar with 10 mL sterile water.
- Add reconstituted medication to prepared bag of Normal Saline 0.9% for a final concentration of 0.4-4 mg/mL.
- Infuse Infliximab or Biosimilar as prescribed.
- Once infusion is complete, flush IV line with Normal Saline 0.9% as prescribed.
- If vital signs are stable 30 minutes after infusion, Skilled Nurse will discontinue IV access and complete visit.

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):
The Skilled Nurse will:

- STOP THE INFUSION.
- Administer emergency medications as prescribed (*below*).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: □ Yes □ No (if yes, please send DOCUMENTATION of consent with order)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ **Printed Name:** _____ **Date:** _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:	**Return completed orders to:**
Address: _____	MultiCare Home/Alternate Infusion Services
Phone #: _____ Fax#: _____	253-459-6650 (*phone*) / 253-864-2785 (*fax*)

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:	Pre-printed order – Page 3 of 3
Name:	Infliximab or Biosimilar Order Set
MRN:	MultiCare Revised 07/24
DOB:	