ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

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

Infliximab (Remicade) or other biosimilars

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis:

- ❑ Rheumatoid Arthritis
- ❑ Crohn's Disease
- ❑ Other_____

ICD -10 Code:

- ❑_____
- ❑_____
- ❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required:

- CBC/CMP Date: _____/_____/_____ Results: _____
- Latent TB testing Date: _____/_____/_____ Results: _____
- HBV screening Date: _____/_____/_____ Results: _____
- HCV screening Date: _____/_____/_____ Results: _____
- HIV screening Date: _____/_____/_____ Results: _____

Maintenance labs required:

- Annual Latent TB testing
- CBC and CMP annually

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Patient weight = _____ lb/kg (required)

Treatment Regimen:

❑ Pre-meds given 30 minutes prior to infusion (pre-meds recommended for first infusion):

- Acetaminophen 650 mg po x 1 dose
- Diphenhydramine 25 mg po x 1 dose or loratadine 10 mg po x 1 dose if intolerant to diphenhydramine

❑ Infliximab (Remicade) or other biosimilar (pharmacist to add MHS or insurance preferred product)

Will be dilute in NS to a final concentration between 0.4-4 mg/ml. Attach a 0.22 micron filter and infuse over at least 2 hours.

Once the patient has been established on treatment, MHS will adopt a shortened duration of infusion over 1 hour for patients </=6 mg/kg. ❑ Yes ❑ No

-- Initiation dose:

❑ 3 mg/kg = _____ mg (round to nearest 100 mg) IV at weeks 0, 2, 6 then every 8 weeks

❑ 5 mg/kg = _____ mg (round to nearest 100 mg) IV at weeks 0, 2, 6 then every 8 weeks

❑ _____ mg/kg = _____ mg (round to nearest 100 mg) IV every _____weeks

-- Maintenance dose:

❑ Continue maintenance dose of _____ mg/kg (round to nearest 100 mg) IV every _____weeks

- ❑ 3 mg/kg = _____mg (round to nearest 100 mg) IV at weeks 0, 2, 6 then every 8 weeks
- ❑ 5 mg/kg = _____ mg (round to nearest 100 mg) IV at weeks 0, 2, 6 then every 8 weeks
- ❑ _____ mg/kg = _____ mg (round to nearest 100 mg) IV every _____ weeks
- ❑ Continue maintenance dose of _____ mg (round to nearest 100 mg) IV every _____ weeks

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify provider of reaction, assessment and need for further orders"

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)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expire in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order

INFLIXIMAB (Remicade) and Biosimilars

MultiCare

78-2030-9MR (Rev. 9/24)