



INFUSION SUITE		INFLIXIMAB INFUSION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500	Fax: 970-828-3501
PATIENT INFORMATION - Include Patient Demographics and Insurance Cards			
Name:		DOB:	
MEDICAL INFORMATION			
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
REQUIRED TESTING			
<input type="checkbox"/> TB: _____ <input type="checkbox"/> Hepatitis B: _____ *Both required annually			
Additional labs:			
<input type="checkbox"/> Insert IV	<input type="checkbox"/> Access Port/PICC		
PREMEDICATIONS 30 minutes prior to starting			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1 <input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1 <input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Solumedrol:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1
<input type="checkbox"/> Antihistamine:	<input type="checkbox"/> Cetirizine 10mg PO X1 <input type="checkbox"/> Loratadine 10mg PO X1		
<input type="checkbox"/> Additional PRN:			
INFLIXIMAB ORDERS <input type="checkbox"/> Biosimilar substitute allowed			
<input type="checkbox"/> REMICADE	<input type="checkbox"/> INFLECTRA	<input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> RENFLEXIS	<input type="checkbox"/> AVSOLA		
<input type="checkbox"/> Loading:	_____ mg/kg IV on Week 0, Week 2, Week 6 OR _____ mg on Week 0, Week 2, Week 6		
<input type="checkbox"/> Maintenance:	_____ mg/kg IV every _____ weeks X _____ OR _____ mg every _____ weeks X _____		
POST INFUSION			
<input type="checkbox"/> Flush IV line with 25mL NS at the same rate of infusion. D/C IV. <input type="checkbox"/> Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess <input type="checkbox"/> Discharge home			
Referring Provider Printed:		NPI:	
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
DNG Provider Printed:			
DNG Provider Signature:		Date:	

*Credentials must be included

*Vital Signs should be monitored with every rate change

Infusion Directions:

- Remove vials and allow to come to room temp before administration
- Reconstitute each vial with 10mL Sterile Water for Injection using syringe and 21G needle or smaller
- Direct the stream of Sterile Water to the wall of the vial to avoid foaming.
- Gently swirl to dissolve the lyophilized powder, do not shake, allow to stand for 5 minutes
- Obtain a 250mL bag of NS, withdraw NS equal to the volume of the infliximab dose from the NS bag
- Withdraw the dose of infliximab from the vial(s) and add slowly into the NS bag, gently invert to mix
- Discard and document any drug waste
- Infuse over 2 hours (minimum) with a low protein binding 1.2micron or less, in-line filter tubing
- Follow titration infusion rate chart below:

Infliximab 250mL infusion rates	Infliximab 500mL Infusion rates (Over 1000mg)
10mL/hour x 15 minutes / 3mL	20mL/hour x 15 minutes / 5 mL
20mL/hour x 15 minutes / 5 mL	40mL/hour x 15 minutes / 10mL
40mL/hour x 15 minutes / 10mL	80mL/hour x 15 minutes / 20mL
80mL/hour x 15 minutes / 20mL	160mL/hour x 15 minutes / 40 mL
150mL/hour x 30 minutes / 75 mL	300mL/hour x 30 minutes / 150mL
250mL/hour x 33 minutes / 137 mL	500mL/hour x 33 minutes / 275 mL

Infliximab Dose Calculator: <https://www.remicadehcp.com/index.html>