DURANGO INFUSION

INFUSION SUITE		INFLIXIMAB INFUSION ORDERS	
Durango Infusion Center		**Phone: 970-828-3500**	**Fax: 970-828-3501**
270 E 8th Ave Ste N101 Durango, CO 81301			
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		
☐ **TB: _____** ☐ **Hepatitis B:_____ *Both required annually**			
Additional labs:			
☐ **Insert IV**	☐ **Access Port/PICC**		
	PREMEDICATIONS 30 minutes prior to starting		
☐ **Acetaminophen:**	☐ 325mg PO X1	☐ 500mg PO X1	☐ 650mg PO X1 ☐ 1000mg PO X1
☐ **Diphenhydramine:**	☐ 25mg IV X1	☐ 25mg PO X1	☐ 50mg IV X1 ☐ 50mg PO X1
☐ **Solumedrol:**	☐ 40mg IV X1	☐ 100mg IV X1	☐ 125mg IV X1
☐ **Antihistamine:**	☐ Cetirizine 10mg PO X1	☐ Loratadine 10mg PO X1	
☐ **Additional PRN:**			
	INFLIXIMAB ORDERS	☐ Biosimilar substitute allowed	
☐ **REMICADE**	☐ **INFLECTRA**	☐ **OTHER:_____**	
☐ **RENFLEXIS**	☐ **AVSOLA**		
☐ Loading:	_____mg/kg IV on Week 0, Week 2, Week 6 OR _____ mg on Week 0, Week 2, Week 6		
☐ Maintenance:	_____mg/kg IV every _____ weeks X _____ OR _____ mg every _____ weeks X _____		
	POST INFUSION		
☐ Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
☐ Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
☐ 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