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CMC0042-001NS Rev. 10/2022

CHST Infliximab (Remicade or Biosimilar) Infusion Therapy Plan (Ophthalmology)

Baseline Patient Demographic

To be completed by the ordering provider.

Diagnosis: _____ Height: _____ cm Weight: _____ kg Body Surface Area: _____ (m_2)

☐ NKDA - No Known Drug Allergies ☐ Allergies: _____

Therapy Plan orders extend over time (several visits) including recurring treatment.

Please specify the following regarding the entire course of therapy:

Duration of treatment: _____ weeks _____ months _____ unknown

Treatment should begin: ☐ as soon as possible (within a week) ☐ within the month

****Plans must be reviewed / re-ordered at least annually. ****

ORDERS TO BE COMPLETED FOR EACH THERAPY

ADMIT ORDERS

☑ **Height and weight**

☑ **Vital signs**
Notify provider of any abnormal vital signs or sign / symptoms of sickness to determine in infusion should continue.

HYPOTENSION DEFINED ADMIT

☑ **Nursing communication**

Notify Provider for Hypotension:
Prior to starting infusion, please determine the patient's threshold for hypotension as defined by the following parameters. This information will be needed in the event of an infusion reaction.
Hypotension is defined as follows:
1 month to 1 year - systolic blood pressure (SBP) less than 70
1 year to 11 years - systolic blood pressure (SBP) less than 70 + (2 x age in years)
11 years to 17 years - systolic blood pressure (SBP) less than 90
OR any age - systolic blood pressure (SBP) drop of more than 30% from baseline.
Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.

PREGNANCY TESTS AT DALLAS AND PLANO

Physician communication order
Routine, ONE TIME
Please select this test if the patient is a female over 10 years of age, per organizational policy.

Nursing communication
Only one pregnancy test is necessary, based on facility capabilities. Please utilize the lab that is available per facility.

☑ Patient requires a pregnancy test (based on organizational policy, female patients over 10 require a pregnancy test)

Pregnancy test, urine - POC
STAT, ONE TIME, for females > 10 years old. If positive, do NOT infuse and contact the ordering provider.

Gonodotropin chorionic (HCG) urine
STAT, ONE TIME, unit collect, for females > 10 years old. If positive, do NOT infuse and contact ordering provider.

NURSING ORDERS

Please select all appropriate therapy

IV START NURSING ORDERS

☐ **Insert peripheral IV / Access IVAD**
Place PIV if needed or access IVAD if available

Key: cm = centimeter; HCG = human chorionic chorionic gonadotropin; IV = intravenous; IVAD= implantable venous access device; kg = kilogram; m² = square meters; mg = milligram; mL = milliliter; mL / hr = milliliters per hour; mm = millimeter; mOsm / l = millisomole per liter; NKDA = no known drug allergies; ODT = orally disintegrating tablet; pH = hydrogen ion concentration; PIV = peripheral intravenous; POC = point of care; PRN = as needed; RTA = ready to administer; SBP = systolic blood pressure; STAT = immediately

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NURSING ORDERS, CONTINUED

Please select all appropriate therapy

☐ **lidocaine 1% BUFFERED (J-TIP LIDOCAINE)**

0.2 mL, INTRADERMAL, PRN

☐ when immediate procedure needed ☐ when procedure will take about 1 minute ☐ patient / family preference for procedure

Administration Instructions: NOTE: Do not use this medication in patients with bleeding disorders, platelets ≤ 20,000, or in patients taking anticoagulants, when accessing implanted ports or using a vein that will be utilized for chemotherapy administration, nor for pre-term infants or neonates.

☐ **lidocaine - prilocaine (EMLA) cream**

TOPICAL, PRN

☐ when more than 60 minutes are available before procedure ☐ when procedure will take more than 1 hour

☐ patient / family preference for procedure

Administration Instructions: NOTE: In children < 3 months of age, or < 5 kg in weight, maximum application time is 1 hour.

☐ **lidocaine - tetracaine (SYNERA) patch**

TOPICAL, PRN

☐ when 20 - 30 minutes are available before procedure ☐ when procedure will take more than 1 hour

☐ when anticipated pain is less than 5 mm from skin surface ☐ patient / family preference for procedure

☐ **lidocaine with transparent dressing 4% kit**

TOPICAL, PRN

☐ when 20 - 30 minutes are available before procedure ☐ when procedure will take more than 1 hour

☐ patient / family preference for procedure

☐ **Heparin flush**

heparin flush

10 - 50 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. This heparin flush should be used with all central lines including IVADs, with the exception of de-accessing the IVAD.

heparin flush

100 - 300 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. For use only when de-accessing IVADs.

☐ **Sodium chloride flush**

Sodium chloride flush 0.9% injection
1 - 20 mL, INTRAVENOUS, PRN, IV line flush

Sodium chloride - preservative free 0.9% injection
1 - 30 mL, INTRAVENOUS, PRN, IV line flush

PRE-PROCEDURE LABS

☐ **Complete blood count with differential** **INTERVAL:** Once **DEFER UNTIL:** _____ **DURATION:** For 1 treatment
Unit collect, ONE TIME, with initial infusion, then every 8 weeks beginning with maintenance dose at week 6.

☐ **Complete blood count with differential** **INTERVAL:** Every 8 weeks **DEFER UNTIL:** _____ **DURATION:** Until discontinued
Unit collect, ONE TIME

☐ **Aspartate Aminotransferase** **INTERVAL:** Once **DEFER UNTIL:** _____ **DURATION:** For 1 treatment
Unit collect, ONE TIME, with initial infusion, then every 8 weeks beginning with maintenance dose at week 6.

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PRE-PROCEDURE LABS, CONTINUED

☐ **Aspartate Aminotransferase** **INTERVAL:** Every 8 weeks **DEFER UNTIL:** _____ **DURATION:** Until discontinued
Unit collect, ONE TIME

☐ **Alanine Aminotransferase** **INTERVAL:** Once **DEFER UNTIL:** _____ **DURATION:** For 1 treatment
Unit collect, ONE TIME, with initial infusion, then every 8 weeks beginning with maintenance dose at week 6.

☐ **Alanine Aminotransferase** **INTERVAL:** Every 8 weeks **DEFER UNTIL:** _____ **DURATION:** Until discontinued
Unit collect, ONE TIME

☐ **Creatinine** **INTERVAL:** Once **DEFER UNTIL:** _____ **DURATION:** For 1 treatment
Unit collect, ONE TIME, with initial infusion, then every 8 weeks beginning with maintenance dose at week 6.

☐ **Creatinine** **INTERVAL:** Every 8 weeks **DEFER UNTIL:** _____ **DURATION:** Until discontinued
Unit collect, ONE TIME

☐ **Quantiferon TB Gold** **INTERVAL:** Day 1 of every 12 months **DEFER UNTIL:** _____ **DURATION:** Until discontinued
Unit collect, ONE TIME

☐ **Anti - Nuclear Antibody ANA** **INTERVAL:** Day 1 of every 6 months **DEFER UNTIL:** _____ **DURATION:** Until discontinued
Unit collect

PRE-MEDICATIONS

☐ **Acetaminophen pre-medication 30 minutes prior (15 mg / kg, maximum 650 mg)**

Nursing communication
Administer only one of the acetaminophen orders, suspension or tablets, do not give both.

acetaminophen suspension
15 mg / kg, ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

acetaminophen tablet
15 mg / kg ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

☐ **Diphenhydramine pre-medication 30 minutes prior (1 mg / kg, maximum 50 mg)**

Nursing communication
Administer only one of the diphenhydrAMINE pre-medication orders, liquid, capsule or injection, do not give more than one of the orders as a pre-medication.

diphenhydrAMINE liquid
1 mg / kg, ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

diphenhydrAMINE capsule
1 mg / kg ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

diphenhydrAMINE injection
1 mg / kg, INTRAVENOUS, 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

☐ **Cetirizine Pre-Med**

Nursing communication
Administer only one of the cetirizine orders, solution or tablet, do not give both.

☐ **cetirizine solution**
for 1 dose
ORAL, ONCE PRN, for itching.
Dose: _____

☐ **cetirizine tablet**
for 1 dose
ORAL, ONCE PRN, for itching.
Dose: _____

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ORDERS TO BE COMPLETED FOR EACH THERAPY

INTRA-PROCEDURE

☑ **Vital signs**
Baseline vitals prior to start of inFLIXimab infusion, then monitor vitals every 15 minutes during inFLIXimab infusion and for 30 minutes after infusion completed.

☑ **Nursing communication**
Routine, ONE TIME, InFLIXimab infusion rates: Must be administered with a 0.2 micron disk filter. Time (minutes) Infusion rate 0
Infusion rate initial therapy at 10 mL / hour x 15 minutes. Increase rate to 20 mL / hour x 15 minutes. Increase rate to 40 mL / hour x 15 minutes. Increase rate to 80 mL / hour x 15 minutes. Increase rate to 150 mL / hour x 30 minutes. Increase rate to 250 mL / hour x 30 minutes. End of infusion.

☑ **Physician communication order**
Routine, ONE TIME, recommended inFLIXimab starting dose = 5 mg / kg. Please enter the dose of inFLIXimab in 'mg' to facilitate prior authorization requirements. Vial size is 100 mg, if possible and clinically acceptable, round to nearest 100 mg. The following order is for loading doses on weeks 0 and 2.

☐ **methylPREDNISolone RTA infusion** **DURATION: Every Treatment**
1 mg / kg INTRAVENOUS, for 1 dose. For doses ≥ to 10 mg / kg, see policy 7.10.16, assess and document heart rate and blood pressure (BP) every 15 minutes during infusion and for 1 hour after the infusion is completed. Doses > 15 mg / kg should be given over a minimum of 1 hour.
Dose: _____

Infliximab (REMICADE or biosimilar) - Loading Dose
Select one product below:

☐ **inFLIXimab (REMICADE or biosimiliar)**

○ **inFLIXimab (REMICADE) in sodium chloride 0.9% 250 mL infusion** **INTERVAL: Every 14 days** **DURATION: For 2 treatments**

INTRAVENOUS, at 125 mL / hr, ONCE, for 1 dose, administered over 2 hours
Must be administered with a 0.2 micron disk filter.

	Rate	Time at that rate
Initial Infusion Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

○ **inFLIXimab (Unbranded) in sodium chloride 0.9% 250 mL infusion** **INTERVAL: Every 14 days** **DURATION: For 2 treatments**

INTRAVENOUS, at 125 mL / hr, ONCE, for 1 dose, administered over 2 hours
Must be administered with a 0.2 micron disk filter.

	Rate	Time at that rate
Initial Infusion Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

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ORDERS TO BE COMPLETED FOR EACH THERAPY

INTRA-PROCEDURE, CONTINUED

○ **inFLIXimab-dyyb (INFLECTRA) in sodium chloride 0.9% 250 mL infusion** **INTERVAL: Every 14 days** **DURATION: For 2 treatments**

INTRAVENOUS, at 125 mL / hr, ONCE, for 1 dose, administered over 2 hours
Must be administered with a 0.2 micron disk filter.

	Rate	Time at that rate
Initial Infusion Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

○ **inFLIXimab-abda (RENFLEXIS) in sodium chloride 0.9% 250 mL infusion** **INTERVAL: Every 14 days** **DURATION: For 2 treatments**

INTRAVENOUS, at 125 mL / hr, ONCE, for 1 dose, administered over 2 hours
Must be administered with a 0.2 micron disk filter.

	Rate	Time at that rate
Initial Infusion Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

☑ **Physician communication order**
Routine, ONE TIME, recommended inFLIXimab starting dose = 5 mg / kg. Please enter the dose of inFLIXimab in 'mg' to facilitate prior authorization requirements. Vial size is 100 mg, if possible and clinically acceptable, round to nearest 100 mg. The following order is for maintenance dosing every 4 weeks, starting at week 6.

Infliximab (REMICADE or biosimilar) - Maintenance Dose
Select one product below:

☐ **inFLIXimab (REMICADE or biosimiliar)**

○ **inFLIXimab (REMICADE) in sodium chloride 0.9% 250 mL infusion** **INTERVAL: Every 4 weeks** **DURATION: Until discontinued**

INTRAVENOUS, at 125 mL / hr, ONCE, for 1 dose, administered over 2 hours
Must be administered with a 0.2 micron disk filter.

	Rate	Time at that rate
Initial Infusion Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

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ORDERS TO BE COMPLETED FOR EACH THERAPY

INTRA-PROCEDURE, CONTINUED

○ **inFLIXimab (Unbranded) in sodium chloride 0.9% 250 mL infusion** **INTERVAL: Every 4 weeks** **DURATION: Until discontinued**

INTRAVENOUS, at 125 mL / hr, ONCE, for 1 dose, administered over 2 hours
Must be administered with a 0.2 micron disk filter.

	Rate	Time at that rate
Initial Infusion Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

○ **inFLIXimab-dyyb (INFLECTRA) in sodium chloride 0.9% 250 mL infusion** **INTERVAL: Every 4 weeks** **DURATION: Until discontinued**

INTRAVENOUS, at 125 mL / hr, ONCE, for 1 dose, administered over 2 hours
Must be administered with a 0.2 micron disk filter.

	Rate	Time at that rate
Initial Infusion Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

○ **inFLIXimab-abda (RENFLEXIS) in sodium chloride 0.9% 250 mL infusion** **INTERVAL: Every 4 weeks** **DURATION: Until discontinued**

INTRAVENOUS, at 125 mL / hr, ONCE, for 1 dose, administered over 2 hours
Must be administered with a 0.2 micron disk filter.

Initial Infusion Rate	10 mL / hour	for 15 minutes
Increase Rate to	20 mL / hour	for 15 minutes
Increase Rate to	40 mL / hour	for 15 minutes
Increase Rate to	80 mL / hour	for 15 minutes
Increase Rate to	150 mL / hour	for 30 minutes
Increase Rate to	250 mL / hour	for 30 minutes
Then stop infusion		Infusion complete

Dose: _____

Therapy Appointment Request

Please select department for the therapy appointment request:

Expires in 365 days

☐ Dallas Special Procedures ☐ Plano Infusion Center ☐ Dallas Allergy ☐ Dallas Transplant ☐ Dallas Neurology

ANTIEMETICS

☐ **Ondansetron PRN Anti-Emetic**

Nursing communication
ONE TIME, administer only one of the ondansetron orders: solution, ODT tablet or IV. Do not give more than one form.

Ondansetron solution (4 mg)
ORAL ONCE PRN, for nausea / vomiting, only give one form (solution, ODT tablet, or IV), for 1 dose.

Dose: _____

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ANTIEMETICS, CONTINUED

Ondansetron ODT tablet (4 mg)
ORAL ONCE PRN, for nausea / vomiting, only give one form (solution, ODT tablet, or IV), for 1 dose.
Dose: _____

Ondansetron injection (4 mg)
INTRAVENOUS, ONCE , for nausea / vomiting, only give one form (solution, ODT tablet, or IV), for 1 dose.
Dose: _____

EMERGENCY MEDICATIONS

☑ **Nursing communication**

1. Hives or cutaneous reaction only – no other system involvement
   PATIENT IS HAVING A DRUG REACTION:
   a. Stop the infusion
   b. Give diphenhydramine as ordered
   c. Check heart rate, respiratory rate and blood pressure every 5 minutes until further orders from provider.
   d. Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation) if not already on one
   e. Notify provider for further orders

2. Hives or cutaneous reaction plus one other system, i.e. abdominal cramping, vomiting, hypotension, altered mental status, respiratory distress, mouth / tongue swelling: **PATIENT IS HAVING ANAPHYLAXIS**
   a. Stop the infusion
   b. Call code – do not wait to give epinephrine
   c. Give epinephrine as ordered
   d. Notify provider
   e. Check vitals including blood pressure (BP) every 5 minutes until the code team arrives.
   f. Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation), if not already on one.
   g. Give diphenhydramine once as needed for hives
   h. May repeat epinephrine every 5 minutes x 2 doses for persistent hypotension and respiratory distress with desaturation until code team arrives.
   i. May give albuterol as ordered for wheezing with oxygen saturation stable while waiting for code team – continue to monitor oxygen saturation.

   Hypotension is defined as follows:
   1 month to 1 year – systolic blood pressure (SBP) less than 70
   1 year to 11 years – systolic blood pressure (SBP) less than 70 + (2 x age in years)
   11 years to 17 years – systolic blood pressure (SBP) less than 90
   OR any age – systolic blood pressure (SBP) drop more than 30% from baseline.
   Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.

☐ **EPINEPHrine Injection Orderable For Therapy Plan**
(AMPULE / EPI - PEN JR. / EPI - PEN) 0.01 mg / kg

0.01 mg / kg, INTRAMUSCULAR, EVERY 5 MINUTES PRN, for anaphylaxis and may be repeated for persistent hypotension and respiratory distress with desaturation until the code team arrives, for 3 doses
Use caution with PIV administration. This solution has a pH < 5, or a pH > 9, or an osmolality > 600 mOsm / L.
Dose: _____

☐ **Cardio / Respiratory Monitoring**
Rationale for Monitoring: High risk patient (please specify risk)
☐ Clinically significant cardiac anomalies or dysrhythmias
☐ Recent acute life-threatening event
☐ Unexplained or acutely abnormal vital signs
☐ Artificial airway (stent, tracheostomy, oral airway)
☐ Acute, fluctuating or consistent oxygen requirements
Monitor Parameters (select all that apply): ☐ Heart rate ☐ Oxygen saturation ☐ Respiratory rate
Telemetry Required: ☐ Yes ☐ No

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POST - PROCEDURE

☐ **Nursing communication**

Flush PIV or IVAD with 20 mL 0.9% sodium chloride (250 mL bag) at the completion of the infusion.
Flush IVAD with saline and heparin flush per protocol prior to de-accessing IVAD.
Discontinue PIV prior to discharge.

☐ **Sodium chloride 0.9% infusion**

INTRAVENOUS at 0 - 25 mL / hr. ONCE, for 1 dose.
Dose: _____

	(circle one): MD DO		
Signature of Provider	Credentials	Date	Time

Printed Name of Provider

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