MUNSON HEALTHCARE

Form 12566 (09/22)

AUTHORIZATION IS GRANTED TO DISPENSE AND ADMINISTER AN ALTERNATE DRUG PRODUCT ACCEPTABLE TO THE MEDICAL STAFF'S PHARMACY COMMITTEE UNLESS THE DRUG PRODUCT IS SPECIFICALLY CIRCLED.

□ MAINTENANCE every ____ weeks for one year.	Estimated treatment initiation date:	Allergies/Reactions:

Diagnosis (Complete One Box Below)

□ Treatment of **moderately to severely active Crohn's disease** (ICD 10 Code _____) (to reduce signs/symptoms and induce and maintain clinical remission) or to reduce the number of draining enterocutaneous and rectovaginal fistulas and maintain fistula closure **PLUS** (must complete below)

□ A. Previous inadequate response to conventional therapy

Drug Failed:

Treatment Dates: From (mm/yy)_____ to (mm/yy)_____.

Reason for Failure:

□ Treatment of **moderately to severely active ulcerative colitis** (ICD 10 Code _____) (to reduce signs/symptoms and induce and maintain clinical remission) or to induce/maintain mucosal healing and eliminate corticosteroid use in adults **PLUS** (must complete below)

□ A. Previous inadequate response to conventional therapy

Drug Failed:

Treatment Dates: From (mm/yy)_____ to (mm/yy)_____.

Reason for Failure:

□ Treatment of **moderately to severely active rheumatoid arthritis** (ICD 10 Code _____) (to reduce signs/symptoms of active arthritis and inhibit progression of structural damage and improve physical function) **PLUS** (must complete below)

□ A. On concurrent methotrexate therapy

□ Treatment of **active ankylosing spondylitis (**to reduce signs/symptoms)
(ICD 10 Code _____)

□ Treatment of **psoriatic arthritis** (to reduce signs/symptoms of active arthritis and inhibit progression of structural damage and improve physical function)
(ICD 10 Code _____)

□ Treatment of **chronic, severe (extensive and/or disabling) plaque psoriasis** as an alternative to other systemic therapy
(ICD 10 Code _____)

Lab orders: CBC with differential and CMP per provider (provide separate order)

Tuberculin Screening complete on
(Date): _____
Results: _____

Hepatitis B Screening complete on
(Date): _____
Results: _____

Weight: _____kg

(Weigh patient prior to each dose, notify provider for fluctuations > 10%)

HOLD treatment & notify provider if:

- Fever or evidence of infection
- LFTs > 5 x ULN

Emetic Risk: Minimal
Monitor:

- For infection
- For infusion related reactions
- Liver function

REMS: Medication Guide provided with each treatment

SAFETY LINE

0.9% NaCl (gravity flow). Use as free-flow for IV push doses (if applicable) and post chemotherapy line flush.

TREATMENT	DOSAGE	ADMINISTRATION INSTRUCTIONS	FREQUENCY
Choose one: **Preferred:** □ **InFLIXimab-abda** (Renflexis) **Alternative:** □ Infliximab-dyyb (Inflectra) □ Infliximab (Remicade-generic) **Reason for selecting alternative:** □ Insurance requirements, including enrollment in patient assistance program □ Intolerance □ **Unless checked,** pharmacy may select alternative biosimilar agent IF preferred by patient's insurance	**_____mg/kg _____ mg** *Dose rounded to the nearest 100mg*	In 0.9% NaCl 250 mL over at least 2 hours Use in-line low protein binding filter (≤1.2 micron) *Infusion should begin within 3 hours of preparation*	x 1 dose per maintenance schedule above

IF PATIENT HAS A HYPERSENSITIVITY REACTION, BEGIN HYPERSENSITIVITY PROTOCOL

Patient Name:

Date of Birth:

The provider's full signature(s) is to follow the order

Provider Signature **Date** **Time**

Provider Printed Name

InFLIXimab MAINTENANCE Dose
(Must sign both pages)

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SYMPTOM MANAGEMENT			
DRUG	**DOSE**	**ADMINISTRATION INSTRUCTIONS**	**FREQUENCY**
□ Acetaminophen	650 mg	Oral	x 1 dose if needed for headache during infusion
□ DiphenhydrAMINE	25mg	IV Push over 1 minute	x 1 dose if needed for itching/rash during infusion

ADDITIONAL ORDERS

For symptomatic hypotension, slow infusion rate. If no improvement, stop infusion, bolus with 125-250 mL 0.9% NaCl and notify provider.

Discontinue IV upon completion of treatment, flush order per protocol.

NURSING INSTRUCTIONS

For InFLIXimab:

1. Monitor vital signs at baseline and every 30 minutes for the first hour or until stable, then every 60 minutes until completion of inFLIXimab infusion.
2. Pulse oximetry PRN dyspnea.

Reference: Arthritis Care Res (Hoboken)2012,64(5):625-39; Arthritis Rheum 2005,52(2):548-53
Am J Gastroenterol 2010, 105(3):501-23; Am J Gastroenterol 2009, 104(2): 465-83; Gastroenterology 2013,145(6):1459-1463

Patient Name:

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InFLIXimab MAINTENANCE Dose
(Must sign both pages)