

REMICADE (INFLIXIMAB) INFUSION ORDERS

Fax to: CASCADE CANCER CENTER
Fax: 425-899-3189 Phone: 425-899-3181

Patient Name: _____ **DOB:** _____

PPD Date: _____ **Result:** _____ **Chest X-ray Date:** _____ **Result:** _____

Weight: _____ **lbs/** _____ **kg | Allergies/reaction:** _____

	DIAGNOSIS	ICD-9 CODE	Recommended Dose (mg/kg)
	Crohn's disease	555.9	mg/kg
	Rheumatoid Arthritis	714.0	mg/kg
	Ankylosing Spondylitis	720.0	mg/kg
			mg/kg

Total Dose _____ **mg (round to nearest 100 mg increment)**

Use Standard Schedule

1st dose: Physician's office to schedule with Cascade Cancer Center

2nd dose: schedule 2 weeks after 1st dose

3rd dose: schedule 6 weeks after 1st dose

Maintenance infusion: every 8 weeks, with first maintenance infusion 8 weeks after 3rd dose

Limit on number of infusions ordered (if not indicated, continuous maintenance doses will be scheduled with medication orders valid for 1 year): _____

Alternate Schedule: _____

Premeds:

Tylenol 650 mg po AND Benadryl 25 mg po

Decadron _____ mg IV

Infusion Plan

First time or history of an infusion reaction:

10 mL/hr	x 15 min
20 mL/hr	x 15 min
40 mL/hr	x 15 min
80 mL/hr	x 15 min
150 mL/hr	x 30 min
250 mL/hr	x 30 min

Monitor patient 30 min post infusion

Subsequent infusions with no reaction: 140 mL/hr; monitor vital signs q 30 mins

If infusion reaction occurs, stop infusion. Restart infusion when symptoms have resolved.

Medications for infusion reactions to use as needed:

Benadryl 25-50 mg IV prn urticaria, pruritis, shortness of breath

Decadron 10 mg IV prn urticaria, pruritis, shortness of breath

Compazine 10 mg IV prn urticaria, pruritis, shortness of breath

MD Signature _____ **Date** _____ **Phone** _____