Instructions to Provider
Review orders and note any changes. All orders with ☑️ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers page 2).
Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all of the following:

☐ Pre-Service Authorization has been obtained by Kaiser Permanente  Fax: 1-888-282-2685  Voice: 1-800-289-1363

Order Date: ________________  Diagnosis:  ICD-10 code (REQUIRED): ________________
Weight: ________kg  ICD-10 description ________________

General Plan Communication
• Special instructions/notes: __________________________________________________

Provider Information
• Live vaccines should not be given concurrently or within 3 months of discontinuation of therapy
• Do not combine with tumor necrosis factor (TNF) agents or other biologic DMARDs.

Infusion Therapy
☒ Infliximab (REMICADE) in 0.9% sodium chloride 250 mL IV infusion

Dose: ☑️ 5 mg/kg  ☐ _____mg/kg x weight (kg) = Total Dose (will be rounded the nearest 100 mg)
Indicate rounded dose: ☐ 300 mg  ☐ 400 mg  ☐ 500 mg  ☐ 600 mg  ☐ 700 mg  ☐ ________ mg
Route: Intravenous
Frequency: Every 8 weeks
Infusion Rate: 10-250 mL/hr titrated. Start infusion rate at 10 mL/hr and slowly increase infusion rate by doubling rate every 15 minutes. After 1 hour, increase to 150 mL/hr for 30 minutes, then increase to 250 mL/hr until infusion complete.

If infusion-related reaction:
1) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD

Note any changes to above regimen:

Pre-Meds
☒ acetaminophen (TYLENOL) tablet
Dose: 650 mg  Route: Oral  Frequency: Once, 30 minutes prior to infliximab infusion.
May also be given once as needed during infusion for achiness, headache, or fever if not given prior to infusion.

☒ cetirizine (ZYRTEC) tablet
Dose: 10 mg  Route: Oral  Frequency: Once, at least 30 minutes prior to infliximab infusion (if not taken at home).

☒ hydrocortisone sodium succinate (SOLU-CORTEF) injectable [not routine; only if breakthrough reaction]
Dose: 50 mg  Route: Intravenous  Frequency: Once PRN, 30 minutes prior to infliximab infusion in addition to acetaminophen and antihistamine if patient still experiences symptoms with acetaminophen and antihistamine alone.
☐ Other: ________________
Dose: ________  Route:  Frequency: Once, 30 minutes prior to infliximab infusion

No routine pre-medications necessary. Above pre-meds may be given if patient has reaction and requires pre-medications for future doses.

Provider Signature: ____________________________  Date: ________________
Printed Name: ____________________________  Phone: ____________________________  Fax: ____________________________

Revision Date: 7/17/2018 Kaiser Permanente  <Reference#115102>
Infliximab (REMICADE) – Maintenance
Infusion Therapy Plan Orders

Page 2 of 2

IV Line Care
- 0.9% sodium chloride infusion 250 mL
  
  Rate: 30 mL/hr  
  Route: Intravenous  
  Frequency: Run continuously to keep vein open
  
- heparin flush 100 unit/mL
  
  Dose: 500 units  
  Route: Intracatheter  
  Frequency: PRN for IV line care per Nursing Policy

Infusion Reaction Meds
- albuterol (PROVENTIL) nebulizer solution 0.083%
  
  Dose: 2.5 mg  
  Route: Nebulization  
  Frequency: PRN for shortness of breath/wheezing
- diphenhydramine (BENADRYL) injectable
  
  Dose: 25 mg  
  Route: Intravenous  
  Frequency: Once PRN, May repeat x1 for urticaria, pruritis, shortness of breath. May repeat in 15 minutes if symptoms not resolved.
- EPINEPHrine 1 mg/mL (1:1000) injectable
  
  Dose: 0.3 mg  
  Route: Intramuscular  
  Frequency: Once PRN for anaphylaxis. Notify physician if administered.
- hydrocortisone sodium succinate (SOLU-CORTEF) injectable
  
  Dose: 100 mg  
  Route: Intravenous  
  Frequency: Once PRN for hypersensitivity

Lab Review for Nursing
- Rheumatology Indications (when labs available in Epic):
  
  * Ensure CBC, ALT, AST, and Creatinine have been drawn within the last 8 weeks.
  * If labs have not been drawn within 8 weeks, proceed with infusion and instruct patient to receive lab draw today.
  * If patient is more than 12 weeks overdue for labs, hold infusion and notify provider.
- GI/Derm Indications (when labs available in Epic):
  
  * Ensure CBC, ALT, AST, and Creatinine have been drawn within the last 12 weeks.
  * If labs have not been drawn within 12 weeks, proceed with infusion and instruct patient to receive lab draw today.
  * If patient is more than 16 weeks overdue for labs, hold infusion and notify provider.

Nursing Orders
- Do not administer infliximab and notify provider if patient has a temperature greater than 100 degrees F, complains of symptoms of acute viral or bacterial illness, or if patient is taking antibiotics for current infection.
- Discontinue IV line when therapy complete and patient stabilized.

References
- REMICADE® Prescribing Information. Revised October 2011.

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3512  
Phone: 425-502-3510

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-2104  
Phone: 206-326-3109

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1659  
Phone: 425-261-1681

Olympia Medical Center
700 Lily Road N.E., Olympia, WA 98506
Fax: 360-923-7106  
Phone: 360-923-7164

Riverfront Medical Center – Spokane
W 322 North River Drive, Spokane, WA 99201
Fax: 509-324-7168  
Phone: 509-241-2073

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7493  
Phone: 360-307-7444

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-383-6262  
Phone: 253-596-3666

Name: ___________________________  
Kaiser Permanente Member I.D. # ___________________________

Date of Birth ________________________________

Provider Signature: ___________________________  
Date: ___________________________

Printed Name: ___________________________  
Phone: ___________________________  
Fax: ___________________________