

Infliximab/Golimumab Orders

Fax all pages to (855) 270-7347

Patient Information

Order Date:	Requested Start of Care Date:	Date of Birth:	
Patient name:	Height:	Weight:	lb / kg
Address:	City:	State:	Zip:
Primary Dx:	ICD-10:		
2° Dx:	ICD-10:	IV Access: <input type="radio"/> Periph <input type="radio"/> Port <input type="radio"/> Other:	
Allergies:			

Clinical History (complete upon initial referral only)

Prescribed drug use: Naive Transfer; on therapy since _____ Past use, but not current Last dose: _____

Tuberculosis (testing recommended before start; most payers require annual testing)
 Last TB test date: _____ TB test result: negative positive No current TB sx
 If pending/ordered lab test, date: _____
 If anti-TB therapy, drug(s) / date(s): _____
 Currently on infliximab or golimumab, no TB test within 12 months; OK to proceed with therapy

Hepatitis B virus (testing recommended before start)
 Last HBV test date: _____ HBV test result: negative positive No current HBV sx
 If pending/ordered lab test, date: _____
 If antiviral therapy, drug(s) / date(s): _____
 Received HBV vaccine series No HBV testing; OK to proceed with therapy

Meds tried & failed:	Meds contraindicated:
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Disease	Not present	Current	Past history	Notes, current / past history detail, pertinent baseline labs
Hepatic disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neutropenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NYHA Functional Class <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV

INFLIXIMAB	GOLIMUMAB
Brand: _____ 100mg vial (pharmacy to select brand unless otherwise noted) _____ mg OR _____ mg/kg	Brand: Simponi Aria® 50mg/4ml vial _____ mg OR _____ mg/kg OR <input type="checkbox"/> 2 mg/kg
<input type="radio"/> At 0, 2 & 6 weeks and then every 8 weeks <input type="radio"/> At 0, 2 & 6 weeks and then every 6 weeks (usual ankylosing spondylitis regimen) <input type="radio"/> Maintenance only: every 8 weeks <input type="radio"/> Maintenance only: every 6 weeks (usual ankylosing spondylitis regimen) <input type="radio"/> Other: _____	<input type="radio"/> At 0 & 4 weeks and then every 8 weeks <input type="radio"/> Maintenance only: every 8 weeks <input type="radio"/> Other: _____
Infuse IV over at least 2 hours as tolerated unless otherwise specified:	Infuse IV over at least 30 minutes.
Round dose to nearest 100 mg or 10 mg for doses <101 mg Decline <input type="checkbox"/>	Round dose to the nearest 50 mg vial Decline <input type="checkbox"/>

Pharmacist to adjust doses ordered in mg/kg if weight changes +/- 10% Decline

+/- _____ days for scheduling flexibility Refill _____ doses (unless noted, all prescriptions valid 1 year from date signed.)

Premedication Orders / Other Orders

Patient Type	Drug	Description / Dispense Quantity Sufficient	Dose	Route / Frequency	Decline
Adult & Pediatric ≥12 years (if not at least 95 lb., follow <12 years dosing)	Acetaminophen	325 mg tab or 160 mg/5 ml oral 120 ml	325 - 650 mg	Orally pre-mAb prn. May repeat q 4 - 6 hr prn. Max 3 gm/day.	Decline <input type="checkbox"/>
Pediatric 0 - 11 years		160 mg/5 ml oral 120 ml	10 mg/kg (round to nearest 1/4 tsp)	Orally pre-mAb prn. May repeat q 4 - 6 hr prn. Max 50 mg/kg/day.	
Adult	Diphenhydramine	25 mg tab or 12.5 mg/5 ml oral 120 ml	25 - 50 mg	Orally pre-mAb prn. May repeat q 4 - 6 hr prn.	Decline <input type="checkbox"/>
Pediatric ≥ 12 years		12.5 mg/5 ml oral 120 ml	25 mg		
Pediatric 6 - 11 years		12.5 mg/5 ml oral 120 ml	12.5 - 25 mg		
Pediatric 2 - 5 years		12.5 mg/5 ml oral 120 ml	6.25 mg		
Adult & Pediatric ≥6 years	Loratadine (if excessive drowsiness from diphenhydramine)	10 mg tab or 5 mg/5 ml oral 120 ml	10 mg	Orally pre-mAb prn. No repeat.	Decline <input type="checkbox"/>
Pediatric 2 - 5 years		5 mg/5 ml oral 120 ml	5 mg		

Infliximab/Golimumab Orders

Patient Name:					
Premedication Orders / Other Orders (continued)					
Patient Type	Drug Description / Instructions - Dispense Quantity Sufficient				
Infliximab	<ul style="list-style-type: none"> • Sterile Water for Injection 10 ml vial (or other available size): Use as directed to reconstitute infliximab. • Sodium chloride 0.9% 250 ml or 500 ml bag: Use as directed to dilute & administer infliximab (make final concentration 0.4 – 4 mg/ml). • Sodium chloride 0.9% 100 ml bag: Use to flush gravity tubing with appx. 25 ml after dose to clear line of drug. <input type="checkbox"/> Decline 				
Golimumab	<ul style="list-style-type: none"> • Sodium chloride 0.9% 100 ml bag: Use as directed to dilute & administer golimumab. Use to flush gravity tubing with appx. 25 ml after dose to clear line of drug. <input type="checkbox"/> Decline 				
All	<ul style="list-style-type: none"> • Lidocaine/prilocaine 2.5%/2.5% cream 30 gm (or other available size): Apply topically 60 min. pre-needle insertion prn discomfort <input type="checkbox"/> Decline 				
Adult & Pedi >15kg	<ul style="list-style-type: none"> • Sodium chloride 0.9% 10 ml syringe: Flush peripheral line pre/post with 1 – 3 ml & may use to reconstitute infliximab <input type="checkbox"/> n/a • Heparin 10 units/ml 5 ml syringe: Flush peripheral line with 1 - 3 ml post last NS. 				
Other Orders:					
Anaphylaxis Orders					
Patient Type	Drug	Description / Dispense Quantity Sufficient	*Reaction Severity	Dose	Route/Frequency
Adult	Diphenhydramine	25 mg tab #24 or	Mild or Severe	50 mg	Orally every 6 hr as needed.
Pediatric		12.5 mg/5 ml oral 120 ml		1.25 mg/kg (max 50 mg)	
Adult & Pediatric >66 lbs	Epinephrine	0.3 mg Auto-Injector #2 or	Severe	0.3 mg	IM (auto-injector) or SubQ (vial/amp) x 1 dose. May repeat in 5 – 15 minutes.
Pediatric 33 - 66 lbs		1 mg/ml 1 ml vial/amp #2		0.15 mg	
Pediatric <33 lbs		0.15 mg Auto-Injector #2 or 1 mg/ml 1 ml vial/amp #2		0.01 mg/kg	
Adult and Pediatric	Sodium chloride 0.9%	250 ml IV Bag #1	Severe	250 ml	Stop causative drug, then administer IV at KVO rate.
<p>*Mild allergic reactions include itching, hives, rash, nausea and/or vomiting</p> <p>*Severe anaphylaxis reactions include angioedema, wheezing, difficulty breathing, swelling of eyelids or lips</p>					
Other Orders:					
Ancillary Supplies and DME Orders (Dispense quantity sufficient)					
Ancillary supplies, including a disposable IV pole, for the infusion of infliximab or golimumab via peripheral IV, port, or indwelling central catheter via gravity or by ambulatory infusion pump.					
Nursing Orders					
<ul style="list-style-type: none"> • Nurse to obtain IV access via placement of peripheral IV or insertion of port needle when applicable. If IV access is not obtained after 3 attempts, nurse should contact Nufactor for assistance. • Nurse to administer infliximab or golimumab and ancillary medications per physician orders 			<ul style="list-style-type: none"> • Nurse to remove peripheral IV catheter after completion of infusion. If peripheral IV, may leave in place up to 5 days as long as no erythema or edema. If port, may leave access device in place up to 7 days. If PICC, change dressing weekly. Nurse to monitor for signs/symptoms of infection/infiltration. 		
Physician Information					
Signature:			Name:		
			NPI#:		
			Address:		
Date:			Phone:		Fax:

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