Lewis County
Health System

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CONFIDENTIAL

DATE: ______________________

PLEASE DELIVER TO: Lewis County Health System – ASU Department

FAX #: 315-376-0130

COMPANY: ______________________

FROM: ______________________

NUMBER OF PAGES (INCLUDING COVER SHEET): 3

SUBJECT: INFUSION REQUEST

NOTES: ______________________

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Lewis County Health System
Your Health Partner

OUTPATIENT SERVICES REQUEST CHECKLIST

What is needed to schedule your patient for treatment at Lewis County General Hospital

Patient Name ______ **DOB** ______ **Patient Phone #** ______

Height ______ **Weight** ______ **Gender** ______ **Allergies** ______

Please attach separate order form for Infusion or procedure (i.e., wound care)

______

Diagnosis/Indications for treatment:

______

Please ensure the following are attached:

☐ **Authorization / Insurance approval completed**

Reference # ______ Date ______

Authorization # ______ Date ______

☐ **Patient Demographic Cover Sheet**

☐ **LCGH specific Order Sheet completed in full?**

- ☐ Patient's name
- ☐ Patient's DOB
- ☐ Diagnosis
- ☐ Patient's current height and weight
- ☐ Allergies
- ☐ Signed, dated, and timed by ordering physician

☐ **Consent completed** (for blood products including IVIG)

☐ **H&P written within 30 days** (which includes purpose for drug)

☐ **Print and fax to LCGH Ambulatory Outpatient Department**

Please make sure **ALL boxes are checked prior to faxing to LCGH ASU
Upon completion, scheduling will be done by LCGH

Provider (or designee) Print Name ______ **Phone #** ______ **Fax #** ______

Provider (or designee's) Signature ______ **Date** ______

Fax completed form to: 315-376-0130 / Contact us directly at: 315-376-5233 / Visit us online at: lcgh.net

Lewis County Health System

DOCTOR'S ORDER SHEET - PHARMACY

Place **patient identification sticker** and/or **two patient identifiers.**

INFLIXIMAB INFUSION - MAINTENANCE

Ht _____ Wt _____kg

ORDERS GOOD FOR THE YEAR OF 20_____

☐ **ADMIT TO ASU OUTPATIENT**

Diagnosis:

Allergies:

Vital Signs: Every 15 minutes during first hour, then every 30 minutes.

IV: 0.9% Normal Saline @ 30ml/hr

Regular Diet

Date of last negative TB ____________________

PRE-MEDICATIONS: SELECT ALL THAT APPLY

☐ Methylprednisolone 40mg IV x 1 - 30 minutes prior to infusion
☐ Diphenhydramine mg PO x 1 - 30 minutes prior to infusion
☐ Diphenhydramine mg IV x 1 - 30 minutes prior to infusion
☐ Acetaminophen 650mg PO x 1 - 30 minutes prior to infusion
☐ Other:

MEDICATION: BELOW PRODUCTS ARE SPECIFIC TO INSURANCE APPROVAL

☐ Inflectra (infliximab-dyyb) ☐ Infliximab
☐ Remicade (infliximab)
☐ Avsola (infliximab-axxg)
☐ Renflexis (infliximab-abda)

Dose of ____________________mg/kg IV in 0.9% NS every 8 weeks (Round to nearest 5 mg)

ADMINISTER INFUSION AS FOLLOWS:

Doses 1-4 of total therapy (or history of infusion reaction)	After 4 initial doses and no history of infusion reaction (only for doses ≤ 1000mg)
10 mL/hr x 15 minutes 20 mL/hr x 15 minutes 40 mL/hr x 15 minutes 80 mL/hr x 15 minutes 150 mL/hr x 30 minutes 250 mL/hr until infusion complete	100 mL/hr x 15 minutes 300 mL/hr until infusion complete

IF INFUSION-RELATED REACTION OCCURS (FOR ALL ORDERS):

1. **STOP infusion**
2. **Alert rapid response team (if clinically indicated)**
3. **Increase 0.9% Normal Saline to 999 ml/hr**
4. **Administer PRN medications per infusion reaction medications listed below**
5. **Notify Physician**
6. **Vital signs every 10 minutes**

INFUSION REACTION MEDICATIONS

Follow reaction infusion protocol unless otherwise indicated (FOR ALL ORDERS):

☐ Albuterol 2.5mg via nebulizer x1 as needed for shortness of breath/wheezing
☐ Diphenhydromine 25mg IV every 15 mnutes x2 as needed for urticaria, Pruritis, shortness of breath
☐ Other:

NURSING ORDERS

- Weight should be recorded at every visit. Notify Pharmacy with patients current weight.
- Notify Pharmacy of dose number and if any history of infusion reaction.
- Recommended for providers to routinely monitor for TB, LFT's, Hepatitis
- Hold infusion and notify MD if patient has signs of infection or significant change in clinical status
- Monitor patient for 30 minutes after infusion complete
- Access port-a-cath, flush with 0.9% NS 10mL post infusion, followed by Heparin 500 units (if applicable)
- Use PICC line, flush with NS 10mL post infusion with 0.9% NS (if applicable)
- Discharge when criteria met

Nurse Signature: ____________________ Date: __________ Time: _________

Qualified Medical Provider Name (Print) : ____________________

Signature: ____________________ NPI# ____________________

Phone Number: ______________ Date: __________ Time: __________

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