Froedtert Health Home Infusion
Infliximab Order Form
Phone: 262-532-5124 | Fax: 262-532-5114

Froedtert & Medical College of Wisconsin
Froedtert Pharmacy

Patient Information		**Physician Information**	
Patient Name:	Date of Birth:	Name:	
MRN #:		DEA #:	NPI:
Address:		Address:	
Phone:		Telephone:	
Allergies:		Fax:	

Prescription Information

Diagnosis: ❑ Crohn's Disease ❑ Rheumatoid Arthritis ❑ Ulcerative Colitis ❑ Psoriatic arthritis ❑ Plaque psoriasis ❑ Ankylosing Spondylitis ❑ Other: _____

TB History: Date of last PPD: _____ Result: _____

CHF History? ❑No ❑Yes

Medication Orders:

Preferred Drug Product (infliximab):

☐ Remicade ☐ Avsola ☐ Inflectra ☐ Renflexis ☐Other _____

QTY/Refills:
☐1 month supply + 12 refills
☐Other: __ month ___ refills

Dose: infliximab ☐ 5 mg/kg ☐ 10mg/kg ☐ Other _____
Dosing Weight: _____ kg (round to nearest multiple of 10mg)
Frequency: Maintenance dosing every _____ weeks
Rate: ☐Infuse according to Froedtert protocol ☐ Other Rate (please provide order)

- Dilute in 250mL 0.9% NaCl to a final concentration of 0.4 to 4 mg/mL
- If change in vital signs (ie: diastolic blood pressure drops 15-20 mmHg) or adverse reaction (ie: urticaria, shortness of breath) occurs, slow or stop infusion immediately. After symptoms have resolved, may resume titration.

Standard 120 infliximab titration	
Rate (mL/hr)	Volume (mL)
50	12.5
75	18.8
100	25
125	31.3
150	162.4
Titrations are every 15 minutes, as tolerated	

Home Infusion Supplies

The below items requested have been reviewed and are authorized to be sent for home administration of infliximab.

Venous access/Flushes
Normal Saline 10mL flush for IV start/post flushing
Qty sufficient, refills PRN

If Venous Access Device: Heparin 100u/mL, 5mL flush as appropriate for line.
Qty sufficient, refills PRN

Anaphylaxis meds
Diphenhydramine 50mg IV
50mg Iv x1 dose as needed for urticarial, pruritis, or SOB
Qty: 1mL vial Refills: 1

Epinephrine 1mg/1ml ampule IV
0.3mg IV slowly PRN anaphylaxis. Repeat every 5-15 min x3 doses.
Qty 1mL ampule Refills: 1

❑**Other**: (indicate name, dose, route, directions): _____

Pre-Medications:

Diphenhydramine – Pre-medicate with:
☐25mg tablet __ tablets(s) by mouth prior to infusion
Qty: 1 each per refill Refills: to match IVIG

Acetaminophen – Pre-medicate with:
☐ 500mg tablet: __ tablet(s) by mouth prior to infusion
Qty 1 bottle (#100) Refills: 0

Other (indicate name, dose, route, and directions):
❑Pre-medicate with: _____
_____

Labs Orders

Labs to draw:
☐ CBC w differential every _____
☐ Hepatic function panel every _____
☐ C-Reactive Protein every _____
☐ Lab: _____every _____

Nursing Orders:

- RN to insert peripheral IV and maintain per protocol
- Monitor vital signs before and after therapy and every 15 minutes during infusion
- If an infusion reaction occurs, decrease rate and monitor vital signs until symptoms subside. If persist or worsens, stop infusion and notify physician.

Physician's Printed Name | Date | Physician's Signature (signature indicates accuracy & completeness of information)