

Name: _____
MRN: _____
DOB: _____

Today's Date _____ Time _____

Diagnosis: _____ Other: _____

Age: _____ Height (cm): _____ Weight (kg): _____ BSA (m²): _____

ALLERGIES/Sensitivities: NKDA or _____

Start Date (at least 1 wk from today): _____ **Urgent (Call Infusion Center)**

Treatment Department: EHW OP Infusion

Appointment Requests: Tolerance: Use default, for chronic treatments order valid for 1 year

Appointment Request – Week 0, 2, 6 - Initial Dosing

Appointment Request – Maintenance Dosing

Every _____ weeks

Starting _____ weeks after initial dose (**note that this should**

align with maintenance schedule)

Treatment Conditions (Administer Treatment if): Once on Day 1

Tuberculosis Test Negative (within 365 days)

NOTE: TESTING SHOULD NOT DELAY TREATMENT

Hepatitis B surface antigen NONREACTIVE (within 365 days)

Okay to treat. Include details here: _____

Labs: Lab (if selected) will be done as per appointment frequency selected above (unless specified)

Hepatitis B Surface Antigen Once

Hepatitis B Core Antibody Total Once

Ferritin Once

Folate Once

Vitamin B12 Once

Vitamin D 25 hydroxy Once

QuantiFERON-TB Gold Plus, once

T-Spot Tuberculosis Test, once

Labs: Lab (if selected) will be done as per appointment frequency selected above (unless specified)

CBC with Diff Once

Comprehensive Metabolic Panel Once

C-Reactive Protein Once

Sedimentation Rate Once

Anser IFX (Infliximab) Prometheus Once

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional

Attending Physician

Print Name: _____

Signature _____

Date _____

Contact # _____

Print Name: _____

Signature _____

Date _____

Contact # _____

[Place patient sticker here]

Name: _____
MRN: _____
DOB: _____

Pre-Medications:

Order will be done as per appointment frequency
 Instructions: Give at least 30 minutes prior to infusion

- Acetaminophen tablet 650 mg, oral, Once
- Diphenhydramine 25mg, once (choose one) tablet, Oral injection, IV
- Loratadine tablet 10 mg, PO, Once
- Famotidine 20 mg, once (choose one) tablet, Oral injection, IV
- Ondansetron 4mg, once (choose one) tablet, Oral injection, IV
- Hydrocortisone sodium succinate injection 100 mg, intravenous, once
- Methylprednisolone sodium succinate (PF) injection 40 mg intravenous, once

Supportive Care:

Order will be done as per appointment frequency

- Sodium chloride 0.9% prime bag 250 ml
250 ml, intravenous, at 0-999, PRN as needed, Prime Bag

Medications:

Hypersensitivity Protocol
 Order will be done as per appointment frequency

Initial infliximab IVPB, intravenous, once

- Weight Based: 3 mg/kg 5 mg/kg 7.5 mg/kg 10 mg/kg
- Flat Dosing: 300 mg 400 mg 500 mg 600 mg 700 mg

Maintenance infliximab IVPB, intravenous, once

- Weight Based: 3 mg/kg 5 mg/kg 7.5 mg/kg 10 mg/kg
- Calculated patient dose: _____

Maintenance infliximab IVPB, intravenous, once

- Flat Dosing: 300 mg 400 mg 500 mg 600 mg 700 mg

Emergency Medications

Order will be done as per appointment frequency

Hypersensitivity reaction protocol

Protocol Document: <https://emory.ellucid.com/documents/view/15307/15641>

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional

Print Name: _____
Signature _____
Date _____
Contact # _____

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____