KAISER PERMANENTE®

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

Infliximab-dyyb (INFLECTRA) – Maintenance
Infusion Therapy Plan Orders

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 at the end of this protocol). 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: _____ **Weight:** _____kg	**Diagnosis:** ICD-10 code *(REQUIRED):* _____ ICD-10 description_____

General Plan Communication

- Special instructions/notes: _____

Provider Information

- Live vaccines should not be given concurrently.
- Do not combine with tumor necrosis factor (TNF) agents or other biologic DMARDs.

Infusion Therapy

☑ **infliximab-dyyb (INFLECTRA) in 0.9% sodium chloride IV infusion** (250 mL or 500 mL; max concentration 4 mg/ml)

Dose: ☐ **3 mg/kg** ☐ **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 ___ weeks**

Infusion Rate: 10 – 1,100 mL/hr titrated.

250 mL bag: Start infusion rate at 10 mL/hr for 15 minutes, then increase to 20 mL/hr for 15 minutes, then 40 mL/hr for 15 minutes, then 80 mL/hr for 15 minutes, then 150 mL/hr for 15 minutes, then 250 mL/hr until infusion complete.

500 mL bag: Start infusion rate at 20 mL/hr for 15 minutes, then increase to 40 mL/hr for 15 minutes, then 80 mL/hr for 15 minutes, then 160 mL/hr for 15 minutes, then 300 mL/hr for 15 minutes, then 500 mL/hr until infusion complete.

60 min Rapid Infusion Rate: Infuse over 60 min at a rate up to 550 mL/hr, depending on volume of bag. May be infused over 60 min if patient agrees and received at least 4 consecutive infliximab (or biosimilar) infusions over 2 hours with no evidence of infusion reaction. Document qualifications prior to administration of 60 min rapid infusion.

30 min Rapid Infusion Rate: Infuse over 30 min at a rate up to 1,100 mL/hr, depending on volume of bag. May be infused over 30 min if patient agrees and received at least 4 consecutive infliximab (or biosimilar) infusions over 1 hour with no evidence of infusion reaction. Document qualifications prior to administration of 30 min rapid infusion.

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: _____

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

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Pre-Meds

☑ acetaminophen (TYLENOL) tablet
Dose: 650 mg *Route:* Oral *Frequency:* Once PRN, 30 minutes prior to infliximab-dyyb infusion (if not taken at home). 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 PRN, at least 30 minutes prior to infliximab-dyyb 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-dyyb infusion in addition to acetaminophen and antihistamine if patient still experiences symptoms with acetaminophen and antihistamine alone.

☐ Other: _____
Dose: _____ *Route:* Oral *Frequency:* Once, 30 minutes prior to infliximab-dyyb infusion

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

IV Line Care

☑ 0.9% sodium chloride infusion 250 mL
Rate: 30 mL/hr *Route:* Intravenous *Frequency:* Run continuously to keep vein open
Start peripheral IV if no central line

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, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

☑ EPINEPHrine (EpiPen) 0.3 mg/0.3 mL IM Auto-Injector
Dose: 0.3 mg *Route:* Intramuscular *Frequency:* Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. Notify physician if administered.

☑ MethylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF).
Dose : 125 mg *Route* : IV push *Frequency:* Once PRN for hypersensitivity reaction. Notify MD if administered.

Lab Review for Nursing

GI/Derm/Rheumatology Indications (when labs available in Epic)**:**

- Ensure CBC, ALT, AST, and Creatinine have been drawn within the last 16 weeks.
- If labs have not been drawn within 16 weeks, proceed with infusion and instruct patient to receive lab draw today.
- If patient has not had labs drawn within 20 weeks, hold infusion and notify provider.

Nursing Orders

- Do not administer infliximab-dyyb 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.
- Document protocol qualifications in the Therapy Plan if patient will receive rapid infliximab-dyyb infusion.
- Administer using a low protein-binding 0.2 micron filter.
- Post infusion observation time per Nursing Standard or as follows: at least 30 minutes for the first 4 infusions, 1-hour for the first rapid 60 min and first rapid 30 min infusion, and per nurse discretion for subsequent infusions.
- Discontinue IV line when therapy complete and patient stabilized.

References

- INFLECTRA® Prescribing Information. Revised June 2021.

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

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Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3811 Phone: 425-502-3820

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-3624 Phone: 206-326-3180

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1578 Phone: 425-261-1566

Olympia Medical Center
700 Lilly Road N.E., Olympia, WA 98506
Fax: 360-923-7609 Phone: 360-923-7600

Riverfront Medical Center – Spokane
W 322 North River Drive, Spokane, WA 99201
Fax: 509-434-3184 Phone: 509-324-6464

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7421 Phone: 360-307-7316

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-596-3351 Phone: 253-596-3350

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____