

## Pediatric Renflexis Infusion Order

**Instructions to Provider:** All orders with  will be placed unless otherwise noted. Please fax completed order, along with referral form.

**Required Lab Results:** Prior to first infusion Hep B and PPD/Quantiferon Gold (fax with order, required prior to scheduling)

### Infusion Therapy:

- Renflexis (infliximab-abda) \_\_\_\_\_ mg IV over \_\_\_\_\_ hours
- Frequency:** weeks 0, 2, and 6, then every \_\_\_\_\_ weeks (loading) **OR** **ICD 10 code:** \_\_\_\_\_
- Frequency:** every \_\_\_\_\_ weeks (maintenance)

### Pre-Meds: Administer 30 minutes prior to Renflexis

- Acetaminophen \_\_\_\_\_ mg PO x 1
- Benadryl \_\_\_\_\_ mg PO or \_\_\_\_\_ mg IV x 1 (*if applicable, only choose ONE*)
- Zofran \_\_\_\_\_ mg IV x 1
- SoluMedrol \_\_\_\_\_ mg IV x 1
- EMLA cream PRN prior to IV start

### Anaphylaxis Medications:

- Epinephrine (1:1000) \_\_\_\_\_ mg SQ/IM; may be repeated after 5mins
- SoluMedrol \_\_\_\_\_ mg IV
- Benadryl \_\_\_\_\_ mg IV

### Additional Orders:

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### Special Instructions:

- Labs: **CBC with diff, CMP, CRP, ESR, LFTs** Frequency: **with every infusion**
- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- Do not administer Renflexis and notify ordering provider if patient has a temperature greater than 100°F, complains of symptoms of acute viral or bacterial illness, or if patient is taking antibiotics for current infection.
- Instruct the family to call the office if patient develops headache, nausea, itching, fatigue or fever

Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_ (Order valid for 1 year)

Patient Name:

DOB:

MRN:

Atrium Health Infusion Centers  
Phone: 704-468-3400 Fax: 704-468-3401

Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_ (Order valid for 1 year)

Patient Name:

DOB:

MRN: