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

Adult Rapid Remicade Infusion Order (Revised 7/14/21)

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 Profile and PPD/Quantiferon Gold (If outside of Atrium, fax with order. Required prior to scheduling.)

Infusion Therapy: **ICD 10 code: _____**

☒ Remicade (infliximab) _____ mg/kg IV over 1 hour *(rounded to the next 100, unless within 10% of 100mg mark then round down)*

☐ **Frequency:** every _____ weeks (Maintenance)

Pre-Meds: <u>Administer 30 minutes prior to Remicade</u> ☐ No Pre-meds Needed

☐ Acetaminophen _____ mg PO x 1
☐ Hydrocortisone _____ mg IV x 1
☐ Benadryl _____ mg PO or _____ mg IV x 1 *(if applicable, only choose ONE)*
☐ Loratadine 10 mg PO x 1
☐ SoluMedrol _____ mg IV x 1

PRN Medications:

☐ Zofran 4mg IV every 3 hours PRN nausea/vomiting

Additional Orders:

_____

Special Instructions:

- **Rate for Maintenance Dose (≤ 1000mg dose):** 250ml/hr x 250mL.
- **Rate for Maintenance Dose (> 1000mg dose):** 500/hr x 500mL.
- Infuse using a 1.2-micron filter or less
- If patient has an infusion reaction and the Remicade* is continued per provider order, the rate will be determined by provider
- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- Do not administer Remicade 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.
- Monitor patient for new onset or worsening congestive heart failure symptoms.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. During loading doses: obtain vital signs after 1st hour of infusion and PRN.
- Monitor for signs of reaction for 30 mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed

Provider Name: _____
Provider Signature: _____
Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: