OUTPATIENT INFUSION ORDER

ALLERGIES *(required)*

REACTIONS *(required if patient has an allergy)*

ALLERGIES

REACTIONS

DATE/TIME

PATIENT STATUS = OUTPATIENT

DIAGNOSIS: *(required)*

ORDER EXPIRATION DATE:
(SIX MONTHS MAX)

ORDER: (Name of Medication, Dose, Route and Frequency):

- ***Pt. weight:*** _____ Kg **(For drug ordering purposes ONLY)**
- **PRE-SCREENING (required):**

TB testing completed on _____*(Date)* **Result**: Positive or Negative *(Circle one)*

Hepatitis B Testing completed on _____ *(Date)* **Result**: Positive or Negative *(Circle one)*

- **PRE-MEDICATIONS** (Administer 30 mins prior to infusion): *Place a check to select medication(s)*

☐ acetaminophen 650 mg PO ONCE, every visit ☐ diphenhydramine 25 mg PO ONCE, every visit

☐ loratadine 10 mg PO ONCE, every visit ☐ diphenhydramine 50 mg PO ONCE, every visit

☐ Other:_____

☐ No pre-medication

- **MEDICATION:** *(Must check to select a medication)*

☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Other: _____

Reason for use of Other:_____

DOSE: (*Must check one*. Pharmacist will dose based on most recent weight and round to nearest vial size)

☐ _____mg in 0.9% sodium chloride, intravenous over 2 hours

☐ 3 mg/kg in 0.9% sodium chloride, intravenous over 2 hours

☐ 5 mg/kg in 0.9% sodium chloride, intravenous over 2 hours

☐ 10 mg/kg in 0.9% sodium chloride, intravenous over 2 hours

☐ _____ mg/kg in 0.9% sodium chloride, intravenous over 2 hours

☐ RAPID Infusion: **Administer over 60 minutes only if patient has received four (4) consecutive infliximab (or biosimilar) infusions without evidence of infusion reaction. Nursing to document qualification criteria prior to administration.**

Initial Interval: *(Must check one or all)*

☐ **0 week** (first dose) ☐ **2 weeks** (2 weeks from first dose) ☐ **6 weeks** (6 weeks from first dose)

Maintenance Interval: (Must check one and fill in the blanks)

RBV
Initials:

*Date: *Time: *Sign: MD#:

MEDICATIONS WILL BE PROCESSED ACCORDING TO THE GENERIC / THERAPEUTIC EQUIVALENT OR STANDARD PROCEDURES APPROVED BY THE PHARMACY AND THERAPEUTICS COMMITTEE. DEVIATIONS MUST BE SPECIFIED BY "DO NOT SUBSTITUTE."

Salinas Valley HEALTH
450 East Romie Lane, Salinas, CA 93901
831-757-4333 | Toll-free 888-755-7864

NS 7176-035940 (Rev. 10/24)

TIME & DATE REQUIRED

POINFOP

OUTPATIENT INFUSION ORDER

***NAME:**

***Date of Birth (DOB):**

OUTPATIENT INFUSION ORDER

ALLERGIES

REACTIONS

ALLERGIES

REACTIONS

DATE/TIME

PATIENT STATUS = OUTPATIENT

DIAGNOSIS: *See page 1*

ORDER EXPIRATION DATE:
(SIX MONTHS MAX)

ORDER: (Name of Medication, Dose, Route and Frequency):

***Select type of line:**

☐ **PICC Line** ***Discontinue*** PICC line on:

- Flush each lumen with 5 ml of Heparin 10 units/ml (50 units) IV prior to discharge. May use Saline flush as an alternative for Heparin allergy.
- Change PICC line dressing every 7 days (3 days if using gauze dressing) and PRN soiled or wet.

☐ **Implanted Port**

- Access port and flush each lumen with 5 ml of Heparin 100 units/ml (500 units) IV prior to de-accessing port. May use Saline flush as an alternative for Heparin allergy.

☐ **Tunneled CVC**

- Flush each lumen with 10 mL Normal Saline daily
- Change dressing every 7 days (2 days if using gauze dressing) and PRN soiled, wet, or no longer occlusive.

☐ **Peripheral Line** insert and discontinue prior to discharge.

☑ **For clotted PICC Line or Implanted Port:** Use Alteplase (Cathflo Activase) 2 mg IV ONCE for each line as needed to de-clot lumen(s). May repeat x1 for each lumen, if unable to de-clot the first time.

☑ **Start Normal Saline infusion at 30 ml/hr.** After infusion of the last medication, flush the line with 50 ml at the same rate as the infused medication rate. Discontinue fluids after flushing. May use **D5W if medication is incompatible with Normal Saline.**

*Date: *Time: *Sign: MD#:

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ALLERGIES

REACTIONS

ALLERGIES

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DATE/TIME

PATIENT STATUS = OUTPATIENT

DIAGNOSIS: ***See page 1***

ORDER EXPIRATION DATE:
(SIX MONTHS MAX)

ORDER: (Name of Medication, Dose, Route and Frequency):

- **NURSING ORDERS:**
  - ❖ Obtain Vital Signs:
    - Upon arrival
    - At the start of infusion
    - At the end of infusion
    - Prior to patient departure
  - ❖ With prior history of acute infusion reaction, monitor VS
    - Every 10 minutes for 30 minutes; then
    - Every 30 minutes during the infusion; then
    - 30 minutes after the infusion
  - ❖ Observe patient for 30 minutes post infusion for FIRST CYCLE ONLY.

☑ **Administer SVH hypersensitivity medications as indicated, based on patient symptoms:**

- Diphenhydramine 50 mg IV push x 1 PRN hives, itching, flushing, swollen lips or tongue
- Famotidine 20 mg IV push x 1 PRN hives, itching, flushing swollen lips or tongue
- Albuterol inhaler 2 puffs PRN SOB, tachypnea or decreased oxygen saturation
- Epinephrine 0.3 mg (Epi-Pen) IM may repeat x 2 at 5 min intervals PRN bronchial constriction, (dyspnea, wheezing, stridor), hypotension
- Methylprednisolone 125 mg IV push PRN hypersensitivity reaction, to prevent biphasic reaction
- Meperidine 25 mg IV x 1 PRN rigors
- Montelukast 10 mg PO PRN wheezing, cough, hives, flushing x 1
- Acetaminophen 650 mg PO PRN fever/chills x 1 (if not given as pre-med)
- Oxygen Protocol PRN for SOB, tachypnea
- Normal Saline 1000 mg Start at TKO for medication administration, Bolus for SBP < 30 mmHg difference from baseline

*Date: *Time: *Sign: MD#:

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