

McLeod Health

Infliximab (Inflectra, Renflexis) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis:

• ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

☐ None

☐ Acetaminophen 650 mg PO

☐ Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg Route: ☐ PO or ☐ IVP

☐ Methylprednisolone: Dose: ☐ 40 mg or ☐ 125 mg Route: IVP

☐ Famotidine: Dose: 20 mg Route: ☐ PO or ☐ IVPB

☐ Other (include drug, dose, and route): _____

Drug Orders:

• Infliximab (Q5103 or Q5104) per 250 mL Sodium Chloride 0.9% IV to infuse over 2 hours

• Dose: ☐ 3 mg/kg ☐ 5 mg/kg ☐ Other: _____ mg/kg ☐ Other: _____ mg

• Frequency: ☐ Induction: Weeks 0, 2, and 6 then every 8 weeks thereafter

☐ Maintenance: every 8 weeks

☐ Other: _____

• Order Duration: One year unless otherwise specified (Other: _____)

Lab Orders:

☐ _____

Standing Orders:

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

• Appropriate access and line care orders per health system policy

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months
- Provide Hepatitis screening (Hepatitis B Surface Antigen) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received infliximab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____
and the last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

- ☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw
☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.