

# 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**

<input type="checkbox"/> McLeod Regional Medical Center (Florence)	<input type="checkbox"/> McLeod Health Loris	<input type="checkbox"/> McLeod Health Cheraw
<input type="checkbox"/> McLeod Health Seacoast (Little River)	<input type="checkbox"/> McLeod Health Dillon	<input type="checkbox"/> 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](mailto:medicationaccessteam@mcleodhealth.org).**