Physician Order – Remicade Infusion
Outpatient Therapy Services

**Physician Order – Remicade Infusion**

| Vitals Signs | | Code Status | | Allergies | | Lab Draws | | Frequency of lab test(s) | | Vascular Access | | Premeds | | Acetaminophen | | Diphenhydramine | | Frequency of Remicade infusions | |
|-------------|---|-------------|---|-------------|---|-------------|---|-------------|---|-------------|---|-------------|---|-------------|---|
| Full Code | DNR | Medications Only | Other (SPECIFY) | | | | | | | | | | | | Series of 3 infusions at weeks 0, 2, and 6 |
| Per Protocol | Q30 minutes | Other (SPECIFY) | | | | | | | | | | | | Infusion Q8 weeks |
| Q8 weeks | Q4 weeks | Q2 weeks | Other (SPECIFY) | | | | | | | | | | | | Other, please specify ________________ |
| Port | PICC | CVC | Start SL | | | | | | | | | | | | 500 mg PO | 1000 mg PO | 25 mg PO | 50 mg PO |
| 5 mg/kg IV | 10 mg/kg IV | | | | | | | | | | | | | | |

**WARNING:** Remicade increases the risk of TB, pneumonia, lymphomas, and can cause hepatotoxicity

- **Frequency** of Remicade infusions
- **Infusion** Q8 weeks
- **Other, please specify** ________________

**Infusion:**
- Include 1.2 micron (or smaller) in-line filter
- Infusion should begin within 2 hours of reconstitution
- Infuse over at least 2 hours
- Begin infusion at 10 mL/hr, increase to 40 mL/hr after 15 – 30 minutes, then after 15 minutes, increase rate to 80 – 250 mL/hour for the duration of the infusion as tolerated. *(Increasing the infusion in increments of 20 – 30 mL/hr every 10 – 15 minutes reduces side effects)*

Keep anaphylaxis kit at patient’s bedside during infusion. Follow anaphylaxis protocol if allergic reaction occurs.

- **Discharge** patient when complete if stable and pain level is within tolerable range
- **Additional Orders** ________________

**Additional Notes:**

- **Remicade DOSE**
  - 5 mg/kg IV
  - May round dose up to full vial amount
  - 10 mg/kg IV
  - Use exact amount only

- **Discharge** patient when complete if stable and pain level is within tolerable range

**Additional Orders** ________________

* Healthcare Provider’s Signature ____________________________

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