INFUSION ORDERS: infliximab - Page 1 of 2

Name:_____ DOB: _____

Diagnosis: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Quantiferon Gold: Date completed:_____ Result:_____

Prescribing provider: Please read carefully

❑ Select this box to have infliximab formulation (Remicade, Inflectra, Renflexis, Avsola) chosen based on St. Peter's Health current formulary product and/or product preferred by the patient's insurance carrier.

OR

❑ If a specific infliximab formulation is required for treatment, choose that individual product below:

- ❑ Remicade (infliximab)
- ❑ Inflectra (infliximab-dyyb)
- ❑ Renflexis (infliximab-abda)
- ❑ Avsola (infliximab-axxq)

Pre-medicate before ❑ First infusion *OR* ❑ All infusions (please check);

- ❑ Acetaminophen 1,000 mg PO X 1
- ❑ Diphenhydramine 25 mg PO X 1
- ❑ Diphenhydramine 25 mg IV X 1
- ❑ Methylprednisolone 125 mg IV X 1
- ❑ Other:_____

Infliximab dose/administration:

❑ infliximab _____mg/kg, (TOTAL mg will be rounded to nearest 100 mg) to be infused over at least 2 hours.

For first infusion initiate at 10 mL/hr
after 15 minutes increase to 20 mL/hour
after 15 minutes increase to 40 mL/hour
after 15 minutes increase to 80 mL/hour
after 15 minutes increase to 250 mL/hour for the remainder of the infusion.

Continued on page 2 ⇨

INFUSION ORDERS: infliximab - Page 2 of 2

(Continued from page 1)

Name:_____ DOB: _____

For subsequent infusions (if there was no infusion reaction with the first infusion)

Titrate as follows:
100 mL/hr for 10 minutes
200 mL/hr for 10 minutes
300 mL/hr for remainder of infusion

Visit Frequency: Three visits: Day 0, 2 weeks after initial visit, and 6 weeks after initial visit followed by infusions every 8 weeks thereafter or_____ weeks.

Lab work:

- ❑ CBC with auto-diff
- ❑ CMP
- ❑ Quantiferon Gold
- ❑ Other: _____

Frequency of lab draws: _____

Diagnosis: _____

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Sign:_____ **Print:**_____ **Date:**_____ **Time:**_____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852
Infusion Orders: Infliximab

ORD.PHY

GENERAL ORDERS: Water Restriction Test

Name: _____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Schedule only when provider is in the office due to their oversight and allow 8 hours for testing.

Purpose:

The water restriction test helps differentiate the possible causes of polyuria in the non-diabetic patient, specifically looking for the diagnosis of diabetes insipidus (central vs nephrogenic).

If the patient has known diabetes mellitus, it is essential that their blood sugars be within reasonable control before proceeding with the test. This can be determined with a finger-stick blood glucose if the patient is diabetic; a reading under 200 mg/dL is considered reasonable.

Patient Preparation Instructions:

Patient should stop drinking two to three hours before arriving for appointment; overnight fluid restriction should be **avoided**, since potentially severe volume depletion and hypernatremia can be induced in patients with marked polyuria. Some patients cannot keep from drinking for three hours due to either severe thirst or the psychological withdrawal response to water. Patients must be monitored closely and be where they can be seen at all times. Some classes of patients with polyuria will do very unusual things to get a drink of water.

Medication Needed from Pharmacy:

❑ Desmopressin 4 mcg subcutaneously
❑ Normal Saline IV – volume and rate to be determined by provider if needed during the test
❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**
***** If necessary call Rapid Response: SPHMG x1970, RMC x5555, or 9-911

Supplies Needed:

❑ Urine collection hat to measure urine output

Laboratory Tests:

Order all tests as STAT priority

- Urine osmolality (**OSMOU**) via clear tube in urine collection kit
- Serum sodium concentration (**NA**) via SST tube
- Serum osmolality (**OSMO**) via SST tube

Risks/Anticipated Side Effects during Testing:

- Hyponatremia leading to seizures
- Hypotension and dehydration

Continued on Page 2 ⇨

PATIENT IDENTIFICATION:

(Continued from page 1)

Testing Process:

Initiation: Measure urine volume (via urine hat) and fill clear tube (from urine collection kit) for urine osmolality (OSMOU) every **one** hour. Collect serum sodium concentration (NA) and osmolality (OSMO) via SST tube every **two** hours.

*Testing continues until meeting one of the following criteria **per the provider**:*

1. The urine osmolality reaches a clearly normal value (above 600 mosmol/kg), indicating that both ADH release and effect are intact. Patients with partial diabetes insipidus may have a substantial rise in urine osmolality, but not to this extent.
2. The urine osmolality is stable on two or three successive hourly measurements despite a rising plasma osmolality. Proceed to step 4.
3. The plasma osmolality exceeds 295 to 300 mosmol/kg or the plasma sodium is 145 meq/L or higher. Proceed to step 4.
4. Administer Desmopressin 4 mcg subcutaneously.
5. Measure urine volume (via urine hat) and urine osmolality (OSMOU) every **30 minutes** for two hours total.
6. At two hours post-desmopressin, draw a serum sodium level (NA) via SST tube. The patient allowed full access to water.

Discharge Criteria:

1. If serum sodium level is normal (136-145 meq/L) then the patient meets discharge criteria.
2. If serum sodium level is abnormal the ordering provider must approve discharge after assessment.
3. Remove IV if started previously.

Provider (Sign):_____(Print):_____Date:_____Time:_____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Water Restriction Test

ORD.PHY

GENERAL ORDERS: Mixed Meal Tolerance Test

Name: _____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Schedule only when provider is in the office due to their oversight and allow 5 hours for testing.

Purpose:

Evaluation of adult patients with documented hypoglycemia due to a cause other than diabetes. Contraindication for testing is diagnosis of diabetes.

Patient Preparation Instructions:

- Explain procedure to patient.
- Ensure adequate dietary carbohydrate (greater than 150 grams/day) for at least 3 days before the test.
- Patient must fast starting at midnight.

Medication Needed from Pharmacy:

Dextrose 5% (D5W) should be spiked and primed along with glucagon in the room for possible administration.

❏ 500 mL D5W 100 mL/hour IV as needed for symptomatic documented low glucose less than 60 mg/dL
❏ Glucagon 1 mg for IV push as needed for unresponsive patient
❏ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**
* If necessary call Rapid Response: SPHMG x1970, or 9-911

Supplies Needed:

❏ Boost High Protein Nutritional Energy Drink kept in Medication Room refrigerator (non-stock item must order; ask charge nurse)

Laboratory Tests:

Infusion Nurse will call the main lab (2950) to notify of testing AND send a copy of the order form with the baseline labs.

Order test as STAT priority:

- **Mixed Meal Tolerance** (MIXMELTOL) via *gray* and *SST* tubes (26 labels should print with interval times)

Risks/Anticipated Side Effects during Testing:

- Monitor the patient for signs and symptoms of hypoglycemia throughout the testing.
- Hypoglycemia, leading to unresponsiveness, coma, or death (tachycardia, fatigue, pallor, tremor, diaphoresis, irritability, hunger, anxiety, confusion, headache, weakness, drowsiness, slurred/difficulty speaking)
- DO NOT ASSUME ALL SYMPTOMS ARE HYPOGLYCEMIC RELATED. For example, patients with gastric surgery can present with dumping symptoms mimicking hypoglycemia.

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PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Mixed Meal Tolerance Test

ORD.PHY

GENERAL ORDERS: Mixed Meal Tolerance Test

Continued from Page 1

Testing Process:

Preparation of patient:

1. Document the time that the patient last ate.
2. Obtain baseline set of complete vital signs.
3. Insert IV, draw baseline serum labs (gray top and SST tubes), and mark time “0 minutes”.
    a. Label all tubes as either ‘symptomatic’ or ‘asymptomatic’.
    b. Gray top tube: glucose level is ran STAT.
    c. SST tube label as “spin & hold” and send to lab: c-peptide and insulin levels ran as a reflex order once glucose reaches 45 mg/dL or patient denotes symptomatic. All unprocessed tubes otherwise discarded at the end of the test.
4. Patient consumes Boost High Protein Nutritional Energy Drink (dose based on 6kcal/kg @ 1kcal/mL = 6 mL/kg) within five minutes while monitored by nursing staff (please see end of order for calculation).

Criteria for Test Completion and Obtaining Blood Samples:

1. Obtain serum labs via one gray top (label stat) and one SST tube (label as “spin & hold”) and send to lab at: 15, 30, 45, 60, 90, 120, 150, 180, 210, 240, 270, and 300 minutes post meal until:
    a. the serum blood glucose are *< 55 mg/dL* or the patient is *symptomatic*, **halt the testing**:
        i. Obtain a serum blood draw via gray top and SST tube
        ii. Document symptoms and closely monitor patient.
2. Check with provider first:
    a. If serum blood glucose is greater than 55 mg/dL and the patient is symptomatic, notify provider for instructions.
    b. If 300 minutes have passed, the patient remains asymptomatic, and the serum blood glucose is above 60 mg/dL, the patient may discharge with no further labs.
3. If nurse feels patient may become unstable then start D5W infusion at 999mL/hr, and notify provider.
4. If patient becomes unresponsive or has seizure-like activity, then initiate rapid response, if needed. Give 1 mg of glucagon via IV push, followed by D5W infusion at 999mL/hr until patient is awake and stable.
    a. Follow with oral carbohydrate intake to prevent rebound hypoglycemia (for example, crackers with cheese or peanut butter).

Discharge Criteria:

1. Once one of the hypoglycemia criteria is noted, then terminate the test and all remaining laboratory tests are cancelled.
2. Once patient’s blood sugars are within normal range and hypoglycemic symptoms have resolve, notify the provider to approve discharge and remove IV.

Boost Dose Calculation:

Patient weight in kilograms multiplied by six equals kilocalories (kg x 6 = kcal)

Concentration of Boost: 310 kcals/274mL

#kcal x 274mL ÷ 310kcals = mL x 0.033814 = fluid oz.

Provider Sign:_____**(Print):**_____**Date:**_____**Time:**_____

PATIENT IDENTIFICATION:

St. Peter’s Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Mixed Meal Tolerance Test

ORD.PHY

INFUSION ORDERS: efartigimod alfa-fcab (Vyvgart ®)

Name: _____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____kg

Diagnosis: _____

efartigimod alfa-fcab dose (round to the nearest 100mg):

- ❑ Weight less than or equal to 120 kg: 10mg/kg IV infusion over 60 minutes once weekly for 4 weeks. Dose = _____ mg/week
- ❑ Weight greater than 120 kg: 1200 mg IV infusion over 60 minutes once weekly for 4 weeks.

- Administer efartigimod alfa-fcab using a 0.2 micron in-line filter.
- Do not co-administer any medications simultaneously through the same infusion line.
- If diluted solution has been refrigerated, allow efartigimod alfa-fcab to come to room temperature before initiating infusion.

❑ **Adverse reaction/anaphylaxis protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ **Time:** _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

INFUSION ORDERS: **efartigimod alfa-fcab** (**Vyvgart ®)**

ORD.PHY