Comanche County Memorial Hospital

General Infusion Center
GI Order

Please fax form to: 580-585-5472

PATIENT DEMOGRAPHICS:

PATIENT NAME: ______	**PATIENT'S CONTACT #:** ______
DATE OF REFERRAL: ______	**ADDRESS:** ______
DATE OF BIRTH: ______	**CITY, STATE, ZIP:** ______
INSURANCE: ______	
HEIGHT: ______ **INCHES** **WEIGHT:** ______ **KG**	**GENDER:** **FEMALE** ☐ **MALE** ☐
ALLERGIES: ☐ **NKDA** ______	

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

☐ **1. INSURANCE CARD (Front & Back)** ☐ **2. PATIENT DEMOGRAPHICS** ☐ **3. MOST RECENT LABS** ☐ **4. MEDICATION LIST**
☐ **5. TRIED/FAILED THERAPIES** ☐ **6. H & P**
☐ **TB Results: Quantiferon Gold Lab, CXR, or PPD (Remicade, Inflectra, Entyvio, Stelara only)** Date of test: ______ ☐ Positive ☐ Negative

LABS:

Lab Orders: ☐ **CBC w/Diff** ☐ **CMP** ☐ **CRP** ☐ **SED rate**
Lab Frequency: ☐ **with each infusion** ☐ **every** ______ **weeks**

PRIMARY MEDICATION ORDER:

☐ **Remicade:** ☐ **Inflectra:**

☐ 3 mg/kg IV at weeks 0, 2, 6 and every ______ weeks thereafter.
☐ 5 mg/kg IV at weeks 0, 2, 6 and every ______ weeks thereafter.
☐ 8 mg/kg IV at weeks 0, 2, 6 and every ______ weeks thereafter.
☐ 10 mg/kg IV at weeks 0, 2, 6 and every ______ weeks thereafter.

Entyvio:

☐ 300 mg IV at weeks 0, 2, 6, and every 8 weeks thereafter.
☐ 300 mg IV every ______ weeks.
☐ 300 mg IV once

Stelara – Induction Dose:

☐ 55 kg or less: 260 mg IV once.
☐ 56 kg to 85 kg: 390 mg IV once.
☐ Greater than 85 kg: 520 mg IV once.

Stelara – Maintenance Dose:

☐ 90 mg subcutaneous injection at week 8 and every 8 weeks thereafter.

Skyrizi – Induction Dose:

☐ 600 mg IV at weeks 0, 4, and 8.

Skyrizi – Maintenance Dose:

☐ 360 mg subcutaneous injection, via on body device, every 8 weeks (beginning at week 12 when using induction dose).

☐ Other: ______

First Dose: ☐ Y ☐ N

☐ Refill x 6 months unless otherwise noted.

☐ Biosimilar or equivalent product may be used according to payer guidelines, unless otherwise specified.

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior to every infusion	PRN
Acetaminophen 650 mg PO	☐	**PRN every ______ hour for mild or moderate infusion reaction**
Diphenhydramine 25 mg PO	☐	**PRN every ______ hour for mild or moderate infusion reaction**
Diphenhydramine 25 mg IV	☐	**PRN every ______ hour for mild or moderate infusion reaction**
Methylprednisolone 125 mg IV	☐	**PRN every ______ hour for mild or moderate infusion reaction**
Other: ______ ______	☐	**PRN every ______ hour for mild or moderate infusion reaction**

LINE USE/CARE ORDERS:

☐ START PIV/ACCESS CVC

☐ FLUSH DEVICE PER CCMH INFUSION POLICY & PROCEDURE

☐ OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☐ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER CCMH INFUSION POLICY AND PROCEDURE (See Reverse Side)

☐ OTHER: (please fax other reaction orders if checking this box)

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PRIMARY DIAGNOSIS:

- ☐ K50 - Crohn's disease (regional enteritis)
- ☐ K50.01 - Crohn's disease of small intestine with complications
- ☐ K50.11 - Crohn's disease of large intestine with complications
- ☐ K50.81 - Crohn's disease of both small and large intestine with complications
- ☐ K50.91 - Crohn's disease, unspecified, with complications
- ☐ K51.01 - Ulcerative (chronic) pancolitis with complications
- ☐ K51.011 - Ulcerative (chronic) pancolitis with rectal bleeding
- ☐ K51.20 - Ulcerative (chronic) proctitis without complications
- ☐ K51.31 - Ulcerative (chronic) rectosigmoiditis with complications
- ☐ K51.51 - Left-sided colitis with complications
- ☐ K51.90 - Ulcerative colitis, unspecified without complications
- ☐ K51.919 - Ulcerative colitis, unspecified with unspecified complications
- ☐ K50.00 - Crohn's disease small intestine without complications
- ☐ K50.10 - Crohn's disease of large intestine without complications
- ☐ K50.80 - Crohn's disease of both small and large intestine w/o complications
- ☐ K50.90 - Crohn's disease, unspecified, without complications
- ☐ K51 - Ulcerative Colitis
- ☐ K51.00 - Ulcerative (chronic) pancolitis without complications
- ☐ K51.019 - Ulcerative (chronic) pancolitis with unspecified complications
- ☐ K51.21 - Ulcerative (chronic) proctitis with complications
- ☐ K51.311 - Ulcerative (chronic) rectosigmoiditis with rectal bleeding
- ☐ K51.81 - Other ulcerative colitis with complications
- ☐ K51.91 - Ulcerative colitis, unspecified, with complications
- ☐ Other: ______________________________

PROVIDER NAME: ______________	**PHONE:** ______________
OFFICE CONTACT: ______________	☐ **FAX:** ______________
ADDRESS: ______________	☐ **EMAIL:** ______________
CITY, STATE, ZIP: ______________	**NPI:** ______________

→ **(DISPENSE AS WRITTEN)**

______________________________ ______________________________
Provider Signature Date/Time

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OUTPATIENT INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of CCMH's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	• Flushing • Dizziness • Headache • Apprehension • Diaphoresis • Palpitations • Nausea / Vomiting • Pruitis	• Chest Tightness • Shortness of Breath • Hypo/hypertension (>20 mmHg Change in Systolic BP from Base-line) • Increased Temperature (>2 Degrees Fahrenheit) • Urticaria	• Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). • Increased Temperature (>2 Degrees Farenheit) with Rigors • Shortness of Breath with Wheezing • Laryngeal Edema • Chest Pain • Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	☐ Administer PRN medications per Physician order	☐ Administer PRN medications per Physician order	☐ Apply oxygen via ambu bag or high flow nasal canula, if vomiting. ☐ Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. ☐ Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midantero-lateral aspect of the thigh; repeat in 5-15 minutes if needed. ☐ Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	☐ Administer PRN medications per Physician order	☐ Administer PRN medications per Physician order	☐ Apply oxygen via ambu bag or high flow nasal canula, if vomiting. ☐ Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. ☐ Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min ☐ Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. ☐ Administer 0.9% naCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS CCMH INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

PHARMACY		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium		
		0.9% Sodium Chloride		*10 Units/mL*	*100 Units/mL*	
PATIENT CLASSIFICATION	**LINE TYPE**	**PRE-ADMIN**	**POST ADMIN**	**POST LAB DRAW**	**POST NS FLUSH***	
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	10 mL	10 mL		5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL	
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL	
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	5 mL	10 mL	3 mL	
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL	
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL	

FOR CHILDREN <33 LBS, CCMH INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

**0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.*