Home Infusion Therapy Plan of Care

Remicade/Inflectra/ Biosimilar

Agency Info	**Elite Infusion Care- NPI 1760148456** **Fax- 424-349-0011 Phone- 714-519-6993 Email- Admin@Eliteinfusioncare.com** **Address: 1440 Harbor Blvd Ste 916 Fullerton, CA**		
Patient Name:			
Date of birth			
Reason for Plan of Care	☐Initial ☐Change in Response to treatment ☐Refill Request ☐ MD order Change		
Plan of Care Development Participation	Patient Participated in the establishment/Maintenance of POC		
Service Location Type	☐In Home ☐ Physician Office Suite		
Ordering Physician		NPI	
Allergies	☐No Known Allergies ☐ other ______________________________		
Diagnosis			
In Office Infusion Therapy Rejected by Patient	☐Yes ☐No		
Start of Care		**# of Refills**	
Medication Order(s)			
Rate of infusion (ML/HR)	Infuse over 2 hrs. If after 4 consecutive of none eventful infusion at 2 hrs. RN May infuse over 1 hour as patient tolerates.		
Mode of Administration	-Medication May be administered via Gravity flow or IV Pump -Nurse may administer medication via Peripheral IV or Central Line		
Pre-medication #1			
Pre-medication #2			
Pre-Medication #3			
Additional Orders			
Anaphylaxis Protocol	•Epinephrine 1:1000 concentration 0.3 ML Sub Q up to 3 doses 15-20 Mins •Benadryl 50 MG IV Over5-10 Min x1 Per Agency/or Pharmacy Protocol	1.STOP infusion. 2.Administer epinephrine and repeat dose if necessary. 3.Administer oral diphenhydramine may administer IV if IV is in place. 4.Initiate CPR (if needed). 5.Call EMS (activate the emergency medical system). 6.Monitor vital signs every 15 mins – elevate legs if hypotensive. 7.Notify prescriber and Director of Nurse/RN Supervisor and pharmacist	
Administration Instruction	*Remove Equal amount of drug from Normal saline bag before adding medication to NS bag *Do not administer infusion and notify pharmacy if patient has a temperature greater than 100 degrees F, complains of symptoms of acute viral or bacterial illness, or if patient *Live vaccines should not be given concurrently. *Do not combine with tumor necrosis factor (TNF) agents or other biologic DMARDs *Administer using a low protein-binding 0.2 micron filter		

Physician reportable Assessment findings	Temp	Blood Pressure	Heart Rate	Respirations	Glucose	Weight
	Temp <96.8 f > 100.4f	SBP <90 or > 150 Diastolic >90	HR < 55 or >110	Resp <12 or >24	glucose <65 >200	> 2 lb/day or >5 lb/week

Functional Limits	☐ None ☐Other________
Safety concerns	☐ None ☐Other________
Diet/Nutritional Needs	☐ None ☐Other________
Nursing Services	**Infusion Services by RN**
	Frequency
	Nurse to Review Patient Medication History, Maintain Medication Profile, Physical, Mental and environment Assessment, Teaching and Education, Monitor response and adherence to treatment
Lab Collection	☐**Lab Collection-Not Ordered**
	Test Ordered: ☐CBC ☐CMP ☐BMP ☐CRP ☐Other________
	Frequency: ☐Weekly ☐Bi-Weekly ☐ Other________
	Method of Collection: Nurse may collect using syringe or Vacuum Assistive device(Luer Lock Attachment), Nurse to collect Via vein-puncture or central line Access Device
IV insertion	Insert Peripheral IV or Access Port-a-Cath via Huber non coring needle PRN for infusion Medication administration
IV removal	•Nurse to Remove Peripheral or Huber Needle at the end of therapy or when needed to replace IV /May leave peripheral iv in for up to 7 days
Agency IV Flush Protocol	Normal Saline 0.9% -10ML IV before/After infusion and PRN for all VAD Maintenance; **Final Flush** Heparin Sodium Flush 300 Units/ 3ML IV PRN for all Central Lines
Patient Specific Therapy Goals	☐Decrease or complete absence of symptoms related to Primary diagnosis ☐Prevent Progression of Disease Prevent Adverse Drug Reactions During Services ☐Maintenance of quality of Life
Discharge Plans	☐Life Long Treatment ☐ D/C when therapy complete ☐D/C when symptoms Stabilized ☐ D/C to Self injection therapy when loading doses complete
Equipment/ Supply Needs	IV Pole, IV insertion Supplies, Normal Saline Flushes, IV Pump, Ancillary Supplies for home infusion administration
Patient Involvement	Patient/ Caregiver agreed to Current plan of care/ Changes Patient/ Family participated in the development of current plan of care

Reviewed by RN		Date Signed			
RN Signature					
Ordering Physician Name		Signature		Date	
Medical Director	Dr. Saba Haq,MD	Signature	Dr Saba Haq	Date	

By Signing (Medical Director)I have reviewed the POC w/nursing staff to ensure POC meet 2 CCR § 74697 requirements and for the initiation of agency protocol orders. All Changes to Primary Medication will require orders from Ordering &/Or Primary Care physician