Infliximab (Remicade, Renflexis, Inflectra, Avsola)

Provider Order Form rev. 9/19/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Crohn's Disease: Ulcerative Colitis: Rheumatoid Arthritis:

Psoriatic Arthritis: Ankylosing Spondylitis: Other:

THERAPY ADMINISTRATION *(Select one)*

☐ Infuse infliximab (Remicade) OR infliximab biosimilar as required by patient's insurance.

☐ Infuse this infliximab product (subject to prior authorization)

_____

DOSING *(Select one)*

☐ _____ mg IV

☐ _____ mg/kg x _____ kg IV = _____ mg

☑ Mix in 250ml of NS for doses less than 999mg. Mix in 500ml NS for doses greater than 1000mg.

FREQUENCY *(Choose one)*

☐ Week 0, 2, 6, and then every 8 weeks

☐ Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC w/ diff ☐ at each dose ☐ every: _____

☐ CMP ☐ at each dose ☐ every: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs/symptoms of illness or active infection/cough, night sweats, or weight loss
- Planned/recent surgical procedures or recent live vaccinations, TB, or Hep B positive.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, biologic agent and steroids, colonoscopy or BSA of affected skin (by indication)

Required Labs: Include negative Hepatitis B within 3 years and Negative TB within 12 months.

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.