

# INFLIXIMAB PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:

Date of Birth:

Address:

Phone:

Height:

inches  cm

Weight:

lbs  kg

## Clinical Information

Primary Diagnosis Description:

ICD-10 Code:

Is this the first dose?

Yes – date of first dose:

No – date of next dose due:

Hepatitis B Status:

Titer Date:

Positive  Negative

TB Status:

PPD (negative) – date:

Last chest x-ray – date:

Past positive TB infection, course taken:

Active TB

Unknown

## Infliximab Prescription

Infliximab (Remicade®) or  Infliximab-dyyb (Inflectra®) or  Infliximab-axxq (Axsola®) or  Infliximab-abda (Renflexis®) refill as directed x 1 year

Initial Dose:  Infuse \_\_\_\_ mg/kg IV on Weeks 0, 2, and 6.

Other: \_\_\_\_\_

Maintenance Dose:  Infuse \_\_\_\_ mg/kg IV every 8 weeks.

Other: \_\_\_\_\_

Dose will be rounded to closest 100 mg vial.

Infusion will be given at a flat rate over 2 hours unless patient has a history of infusion-related reaction(s), and then will infuse with a titrated rate. Check here  for a different infusion rate than the one listed above and detail out the infusion instructions below:

## Ancillary Orders

### Anaphylaxis Kit

- Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
  - Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
  - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

### Medication Orders

- Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.
- Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.
- Other: \_\_\_\_\_

### IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

### Lab Orders

- No labs ordered at this time.
- Other: \_\_\_\_\_

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

**CONFIDENTIAL HEALTH INFORMATION:** Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.