

INFLIXIMAB PRESCRIBER ORDER FORM					
Patient Name:			Date of Birth:		Gender:
Address:					
Phone:			Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information					
Primary Diagnosis Description:				ICD-10 Code:	
Allergies: <input type="checkbox"/> NKDA OR (List):					
Is this the first dose?			Hepatitis B Status:		
<input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of last dose:			Titer Date: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		
TB Status:	<input type="checkbox"/> PPD (negative) – date: <input type="checkbox"/> Last chest x-ray – date: <input type="checkbox"/> QuantiFERON or T Spot Assay result and date: _____ <input type="checkbox"/> Past positive TB infection, course taken: _____				
Infliximab Prescription					
<input type="checkbox"/> Infliximab biosimilar (e.g., Inflectra, Avsola, or Renflexis) as permitted by patient's insurance <input type="checkbox"/> Infliximab (Remicade®)					
Initial Dose: <input type="checkbox"/> Infuse _____mg/kg IV on Weeks 0, 2, and 6. <input type="checkbox"/> Other: _____					
Maintenance Dose: <input type="checkbox"/> Infuse _____mg/kg IV every 8 weeks. Refill as directed x1 year. <input type="checkbox"/> 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. ACCELERATED INFUSION: After 4 consecutive lifetime doses without adverse reactions, administration time may be reduced to 1 hour per the following protocol: 100 mL/hr x 15 min, followed by up to 300 mL/hr x 45 minutes if there are no adverse reactions. (Doses >1000mg require 500ml volume and will be administered 200mL/hr x 15 min, followed by up to 600 mL/hr x 45 minutes.) <input type="checkbox"/> Decline Accelerated Infusion <input type="checkbox"/> Other Infusion Rate: _____					
Ancillary Orders					
Anaphylaxis Kit Dosage: <ul style="list-style-type: none"> ▪ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ 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 – 25 mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement. ▪ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. 					
Medication Orders <input type="checkbox"/> Acetaminophen 650 mg PO 30 min before infusion. Patient may decline. <input type="checkbox"/> Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline. <input type="checkbox"/> Other: _____					
IV Flush Orders <ul style="list-style-type: none"> • <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. • <u>Implanted Port:</u> 0.9% Sodium Chloride 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 <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> 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. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.					
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>					
Prescriber Signature:				Date:	
Prescriber Information					
Prescriber Name:			Phone:		Fax:
Address:			NPI:		
City, State:		Zip:		Office Contact:	
Fax completed form, insurance information, and clinical documentation to: 713-983-4647					
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