



option care health®

Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,
Option Care Health

INFLIXIMAB PRESCRIBER ORDER FORM

Patient Name: _____ Date of Birth: _____ Gender: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code: _____

Allergies: NKDA OR (List): _____

Is this the first dose? Yes – date of first dose: _____
 No – date of last dose: _____

Hepatitis B Status: _____ Titer Date: _____
 Positive Negative

TB Status: PPD (negative) – date: _____
 Last chest x-ray – date: _____
 QuantiFERON or T Spot Assay result and date: _____
 Past positive TB infection, course taken: _____

Active TB Unknown
 Other: _____

Infliximab Prescription

Infliximab biosimilar (e.g., Inflectra, Avsola, or Renflexis) as permitted by patient's insurance

Infliximab (Remicade®)

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

Maintenance Dose: Infuse _____ mg/kg IV every 8 weeks. Refill as directed x1 year.
 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.) Decline Accelerated Infusion

Other Infusion Rate: _____

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) 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

- 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:** 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port:** 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

- 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.

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 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.