

<b>INFLIXIMAB PRESCRIBER ORDER FORM</b>						
<b>Patient Name:</b>			<b>Date of Birth:</b>		<b>Gender:</b>	
<b>Address:</b>						
<b>Phone:</b>			<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b>	
<b>Clinical Information</b>						
<b>Primary Diagnosis Description:</b>					<b>ICD-10 Code:</b>	
<b>Allergies:</b> <input type="checkbox"/> NKDA OR (List):						
<b>Is this the first dose?</b>			<b>Hepatitis B Status:</b>		<b>Titer Date:</b>	
<input type="checkbox"/> Yes – date of first dose:			<input type="checkbox"/> Active TB		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
<input type="checkbox"/> No – date of last dose:			<input type="checkbox"/> Unknown			
<b>TB Status:</b>	<input type="checkbox"/> PPD (negative) – date:		<input type="checkbox"/> Other: _____			
	<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: _____					
<b>Infliximab Prescription</b>						
<input type="checkbox"/> Infliximab biosimilar (e.g., Inflectra, Avsola, or Renflexis) as permitted by patient’s insurance						
<input type="checkbox"/> Infliximab (Remicade®)						
<b>Initial Dose:</b> <input type="checkbox"/> Infuse _____mg/kg IV on Weeks 0, 2, and 6.						
<input type="checkbox"/> Other: _____						
<b>Maintenance Dose:</b> <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.						
<b>ACCELERATED INFUSION:</b> 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 45minutes 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: _____						
<b>Ancillary Orders</b>						
<b>Anaphylaxis Kit</b>						
Dosage: <input type="checkbox"/> 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.						
<input type="checkbox"/> 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.						
<input type="checkbox"/> 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.						
<b>Medication Orders</b>						
<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: _____						
<b>IV Flush Orders</b>						
• <b>Peripheral:</b> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.						
• <b>Implanted Port:</b> 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.						
<b>Lab Orders</b>						
<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>						
<b>Prescriber Signature:</b>					<b>Date:</b>	
<b>Prescriber Information</b>						
<b>Prescriber Name:</b>			<b>Phone:</b>		<b>Fax:</b>	
<b>Address:</b>			<b>NPI:</b>			
<b>City, State:</b>		<b>Zip:</b>	<b>Office Contact:</b>			
<b>Fax completed form, insurance information, and clinical documentation to: 713-983-4647</b>						
<small><b>CONFIDENTIAL HEALTH INFORMATION:</b> 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. <b>IMPORTANT WARNING:</b> 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.</small>						

**Not valid for use for patients residing in Arizona, New York, and Wisconsin**