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. Refill x 1 year.

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 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.) ☐ 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:**

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

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

