


INFLIXIMAB PRESCRIBER ORDER FORM

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

	Patient Name:		Date of Birth:		
	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:		
Is this the first dose? <input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of next dose due:		Hepatitis B Status: Titer Date: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		
TB Status:	<input type="checkbox"/> PPD (negative) – date:	<input type="checkbox"/> Active TB <input type="checkbox"/> Unknown		
	<input type="checkbox"/> Last chest x-ray – date:	<input type="checkbox"/> Other: _____		
	<input type="checkbox"/> Past positive TB infection, course taken: _____			

Infliximab Prescription

Infliximab (Remicade®) or Infliximab-dyyb (Inflectra®) or Infliximab-axxq (Avsola®) or Infliximab-abda (Renflexis®) refill as directed x 1 year.
 Other: _____ 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.
 Other Infusion Rate: _____

ACCELERATED INFUSION: Based on this patient's history of no adverse reactions over at least 4 consecutive doses, reduce administration time 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.

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:	

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