oasis
FAMILY HEALTH NP RN

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Infliximab (Remicade, Avsola, Inflectra, Renflexis)

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ TB status & date (list results here & attach clinicals)

_____

☐ Hepatitis B status & date (list results here & attach clinicals)

_____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg | ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____

Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

Many payors require patients start therapy with an infliximab biosimilar.
Choose ONE of these two options:

☐ 1. Infuse infliximab (Remicade) OR infliximab biosimilar as required by patient's insurance.
☐ 2. Infuse this infliximab product (subject to prior authorization):

_____
(Products include: Remicade, Avsola, Inflectra and Renflexis)

☐ Mix in 250ml 0.9% sodium chloride, intravenous infusion over two hours (use in line filter 1.2 micron or less)
- Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg
- ☐ Other: _____
- ☐ Round up to nearest 100mg OR ☐ Give exact dose
- ☐ Frequency: ☐ induction: week 0, 2, 6, and then every 8 weeks/
  - maintenance: every 8 weeks / ☐ other: _____
  - Infusion rate: 10ml/hr x 15 min
  - Increase to: 20ml/hr x 15 min, 40ml/hr x 15 min, 80ml/hr x 15 min, 150ml/hr x 30 min, 250ml/hr until complete

☐ Flush with 0.9% sodium chloride at infusion completion
☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ other: _____
(If additional treatments are needed, please submit a new order form.)

* Perform test for latent TB; if positive, start treatment for TB prior to starting treatment. Monitor all patients for active TB during treatment, even if initial latent TB test is negative.

* Patients should be tested for HBV infection before initiating TNF blocker therapy, including REMICADE. For patients who test positive for hepatitis B surface antigen, consultation with a physician with expertise in the treatment of hepatitis B is recommended.

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK