

# Infliximab (Remicade)

## 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: \_\_\_\_\_

## SPECIAL INSTRUCTIONS

\_\_\_\_\_

### 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.)

## 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