INFLIXIMAB PRESCRIBER ORDER FORM

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

option care health	**Patient Name:**			**Date of Birth:**	
	Address:				
	Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose?	☐ Yes – date of first dose: ☐ No – date of next dose due:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative

TB Status:	☐ PPD (negative) – date: ☐ Last chest x-ray – date: ☐ Past positive TB infection, course taken: _____	☐ Active TB ☐ Unknown ☐ Other: _____

Infliximab Prescription

☐ **Infliximab (Remicade®) *or*** ☐ **Infliximab-dyyb (Inflectra®) *or*** ☐ **Infliximab-axxq (Avsola®) or** ☐ **Infliximab-abda (Renflexis®) 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:**

