Phone: (844) 598-2557 Fax: (888) 388-1309

Infliximab Prescriber Order Form

Please Fax completed form with patient's demographics,Clinical notes, and recent labs to (888) 388-1309

PATIENT

Patient Name: ______________________ ❑ Male ❑ Female **SS#:** ______________ **DOB:** ______________

Address: ______________________ **City, State, Zip:** ______________________

Primary Phone: ______________ ❑ Home ❑ Cell ❑ Work **Alternate Phone:** ______________ ❑Home ❑Cell ❑Work

Email: ______________________

Allergies: ______________________

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

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 _______ 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.

☐ 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 If this is a 1st infusion dose, would you like SandsRx Pharmacy to provide an anaphylaxis kit with the 1st dose?
☐ Yes ☐ No

Dosage:
- •Give Diphenhydramine capsule (s) 25 mg to 50 mg PO as needed **#4 capsules**
- •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. **#2 vials**
- •Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. **#1 vial**
- •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.

Pre- Medication Orders
- ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.
- ☐ Loratadine 10 mg PO 30 min before infusion. Patient may decline.
- ☐ Methylprednisolone Succinate _____ mg IV push 20 minutes prior to infusion.
- ☐ Other: ______________________

IV Flush Orders
- ☐ Peripheral: NS 3-5 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 Nursing Visits: As needed for IV access, administration and appropriate clinical monitoring. Administration procedures to be followed per protocol. Pump and supplies as needed for administration and appropriate disposal of infusion materials. 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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