

INFLIXIMAB ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

New Referral
 Dose or Frequency Change
 Order Renewal

Is this the first dose? Yes No, date of last infusion: _____ Line type: PIV PICC Port Other

DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	ICD-10 Code: _____
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD-10 Code: _____
<input type="checkbox"/> Rheumatoid Arthritis	ICD-10 Code: _____
<input type="checkbox"/> Ankylosing Spondylitis	ICD-10 Code: _____
<input type="checkbox"/> Psoriatic Arthritis	ICD-10 Code: _____
<input type="checkbox"/> Plaque Psoriasis	ICD-10 Code: _____
<input type="checkbox"/> Diagnosis: _____	ICD-10 Code: _____

REQUIRED DOCUMENTATION

This signed order form by the provider
 H&P and Clinical/Progress notes supporting primary diagnosis
 Patient demographics AND insurance information
 Labs and Tests supporting primary diagnosis

MEDICATION ORDERS

Initial Dosing	<input type="checkbox"/> Infliximab _____mg/kg IV at week 0, 2, 6 then every 8 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Infliximab _____mg/kg IV every 8 weeks
Alternative Dosing	<input type="checkbox"/> Infliximab _____ IV every _____ weeks
	<input type="checkbox"/> Round to the nearest 100mg vial

Refills: X 6 months X 1 Year Other: _____
*(if not indicated, order will expire 1 year from date signed)

Preferred Brand: No Preference

Avsola
 Inflectra
 Remicade
 Renflexis

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
 RN to flush and lock VAD/CVAD per company protocol
 Other: _____

PREMEDICATION ORDERS

Acetaminophen 650mg PO prior to infusion
 Other: _____
 Diphenhydramine 25mg PO prior to infusion
 Other: _____

EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
 Acetaminophen 325mg-650mg PO
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.3mg IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
 Diphenhydramine 25mg slow IV push over 2-5 mins
 Acetaminophen 325mg PO
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____
 Office Phone: _____ Office Fax: _____
 Prescriber Signature: _____ Date: _____