Palmetto INFUSION

Phone: 1-800-809-1265 Fax: 1-866-872-8920

MRN:_____

DOB:_____

STANDARD INFLECTRA® (infliximab-dyyb) PLAN OF TREATMENT FOR RHEUMATOLOGY

NOTE: Patient ***may be ineligible*** to receive (infliximab-dyyb) if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new or worsening symptoms of CHF, new-onset or deterioration neurological changes, and/or surgery.

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies:_____

3. Diagnosis: *** Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing**

☐ **M05.**_____Rheumatoid Arthritis with Rheumatoid factor ☐ **M06.**_____Rheumatoid Arthritis without Rheumatoid factor

☐ **L40.5**_____Psoriatic Arthropathy ☐ **M45.**_____Ankylosing Spondylitis ☐ **D86.0** Sarcoidosis of the Lung

☐ Other **ICD-10 Code**:_____ **Diagnosis description:**_____

4. Pre-medications: ***Administered 30 minutes prior to infusion as selected:***

****Product information suggests premedication of antihistamines, acetaminophen, and/or corticosteroids.***

a) Acetaminophen:
- □ 650mgs PO
- □ 500mgs PO
- □ 325mgs PO

b) Diphenhydramine: □ 25 mgs PO, □ 50mgs PO, □ 25 mgs IVP, □ 50mgs IVP or

c) Alternate oral antihistamine to diphenhydramine:
□ Cetirizine 10 mg, □ Loratadine 10 mg, Fexofenadine □ 60mgs or □ 180mgs

d) Other: Methylprednisolone □ 40mgs IVP □ 125mgs IVP or other_____mgs IVP
Famotidine: □ 20mgs PO, □ 40mgs PO, □ 20mgs IVP, □ 40mgs IVP

e) Pre-medicate with other: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.

5. Order: ☐ INFLECTRA®(infliximab-dyyb) 3 mg/kg per 250 ml Sodium Chloride 0.9% IV to infuse over at least 2 hours ***OR***
☐ Other Dose:____mg or_____mg/kg per 250 - 500 ml Sodium Chloride 0.9% IV

6. Frequency: ☐ Induction orders to be completed at 0 week, 2 week, and 6 weeks

☐ Maintenance Orders every 8 weeks

☐ Special Orders: _____

Lab orders with infusions: _____

7. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____

8. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms available at www.palmettoinfusion.com

Revised 4/20/17

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DOB:_____

Guidelines for Prescribing INFLECTRA® (infliximab-dyyb) for Rheumatology

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis. INFLECTRA® is a bilosimilar to Remicade® that is indications for:**

- **Rheumatoid Arthritis in combination with methotrexate**: reduces signs and symptoms, inhibits the progression of structural damage, and improves physical function in patients with moderately to severely active disease. Dose in conjunction with methotrexate of 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every 4 weeks.
- **Ankylosing Spondylitis**: indicated for dosing at 5 mg/kg induction & then every 6 weeks.
- **Psoriatic Arthritis & Plaque Psoriasis**: indicated for dosing at 5 mg/kg induction & then every 8 weeks.

___ If patient is switching biological therapies, then MD must specify wash-out period prior to starting INFLECTRA® as specified of_____weeks. Last known biological therapy:_____and last date received:_____. (Include copy of last INFLECTRA® infusion record if available and currently on therapy)

___ Other as requested: _____

Pre-Screening:

___ **Required TB screening results: PPD or QuantiFERON Gold Test.**
(* If screening results are positive or indeterminate, then a negative CXR result is required.)

___ **Required Hepatitis screening to include: Hepatitis B Surface Antigen results.**

** Warnings/Precautions: ***Product information suggests that patients who have stopped treatment for an extended period are at higher risk for hypersensitivity reactions. MD should evaluate premedication and consider antibody testing prior to restart of infliximab* or biosimilar.** Patient should not have an active ongoing infection, signs or symptoms of malignancy, or invasive fungal infection. Do not initiate INFLECTRA® therapy in patients with moderate to severe Congestive Heart Failure. ***INFLECTRA ®at doses of >5 mg/kg should not be administer to patients with moderate to severe heart failure.*** Patient with mild CHF should be closely monitored. Therapy should be discontinued in patients who develop new or worsening symptoms of heart failure. **Hepatotoxicity:** Stop therapy in case of jaundice and/or marked liver enzyme elevations. Evaluation of immunizations should be completed prior to and live vaccines should not be given before or concurrently with INFLECTRA®. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Revised 4/20/17