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Palmetto INFUSION

MRN:_____

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

DOB:_____

STANDARD INFLECTRA® (infliximab-dyyb) PLAN OF TREATMENT

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: 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:	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
□ 650mgs PO □ 500mgs PO □ 325mgs PO	

e) Pre-medicate with other: _____

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

5. Dose: ☐ 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 11/24/2021

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DOB:_____

Standard Guidelines for Prescribing INFLECTRA® (infliximab-dyyb)

(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.**

☐ 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: _____

Required Pre-Screening:

☐ **TB screening test completed. Results** (positive or negative): _____

☐ **Hepatitis B screening test completed. Results** (positive or negative): _____

***If TB or Hep B results are positive, please send documentation of treatment or medical clearance.**

** 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.