

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:
<input type="checkbox"/> 650mgs PO
<input type="checkbox"/> 500mgs PO
<input type="checkbox"/> 325mgs PO | b) Diphenhydramine: <input type="checkbox"/> 25 mgs PO, <input type="checkbox"/> 50mgs PO, <input type="checkbox"/> 25 mgs IVP, <input type="checkbox"/> 50mgs IVP or
c) Alternate oral antihistamine to diphenhydramine:
<input type="checkbox"/> Cetirizine 10 mg, <input type="checkbox"/> Loratadine 10 mg, Fexofenadine <input type="checkbox"/> 60mgs or <input type="checkbox"/> 180mgs
d) Other: Methylprednisolone <input type="checkbox"/> 40mgs IVP <input type="checkbox"/> 125mgs IVP or other _____ mgs IVP
Famotidine: <input type="checkbox"/> 20mgs PO, <input type="checkbox"/> 40mgs PO, <input type="checkbox"/> 20mgs IVP, <input type="checkbox"/> 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: _____

MRN: _____

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**.

___ 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 biosimilar 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.**



Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.