



Palmetto
INFUSION[®]

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

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Infliximab Unspecified Plan of Treatment for Dermatology

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
	See list NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

L40.5 - Psoriatic Arthritis/Arthropathy
L40. - Psoriasis
- Other:

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	TB screening
6	HBV screening/labs as required by payor

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
	NEXT INFUSION DATE:
IF ORDER CHANGE:	
Continue current order until insurance approved	

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive infliximab 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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

Premedication with antihistamines, acetaminophen, and/or corticosteroids may be considered to prevent infusion-related reactions.

IV	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

DRUG PRODUCT:

<input type="checkbox"/>	Remicade
<input type="checkbox"/>	Avsola
<input type="checkbox"/>	Inflectra
<input type="checkbox"/>	Renfлекс

Biosimilar may be used according to payer guidelines

If selected, prescriber must sign substitution permitted line

DOSE:

<input type="checkbox"/>	5mg/kg diluted in NS infused IV per step protocol over 2 hours
<input type="checkbox"/>	Other:
<input type="checkbox"/>	May utilize expedited infusion per step protocol to run over 1 hour as tolerated

FREQUENCY:

<input type="checkbox"/>	Induction to be completed at week 0, week 2, and week 6, and then every 8 weeks thereafter
<input type="checkbox"/>	Maintenance every 8 weeks
<input type="checkbox"/>	Infuse every _____ weeks

SPECIAL/LAB ORDERS:

<input type="checkbox"/>	
<input checked="" type="checkbox"/>	Refills x 12 months unless noted otherwise here:

Prescriber confirms that the patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment.

Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.

LINE USE/CARE ORDERS:

<input checked="" type="checkbox"/>	Start PIV/Access CVC
<input checked="" type="checkbox"/>	Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE:

Dispense as written/Brand medically necessary	Substitution permitted