Palmetto INFUSION®

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

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Infliximab Unspecified Plan of Treatment for Gastroenterology

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)

☐	K50.0___ - Crohn's Disease (small intestine)	☐	K51.5___ - Left sided Ulcerative (chronic) Colitis
☐	K50.1___ - Crohn's Disease (large intestine)	☐	K51.0___ - Universal Ulcerative (chronic) Pancolitis
☐	K50.8___ - Crohn's Disease (small & large intestine)	☐	K51.8___ - Other Ulcerative (chronic) Colitis
☐	K50.9___ - Crohn's Disease, unspecified	☐	K60.3___ - Anal Fistula
☐	K63.2- Fistula of Intestine	☐	_____ - Other:

REQUESTED DOCUMENTATION:

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

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

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				
	Methylprednisolone	☐	40mg	☐	125mg	☐	Other:		
	Famotidine	☐	20mg	☐	40 mg				
	Other:	☐							

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

SPECIFIC MEDICATION:

- ☐ Remicade
- ☐ Avsola
- ☐ Inflectra
- ☐ Renflexis

☐ **Any infliximab biosimilar may be used according to payer guidelines**

DOSE:

- ☐ 5mg/kg diluted in NS infused IV per step protocol over 2 hours
- ☐ Other:_____
- ☐ May utilize expedited infusion per step protocol to run over 1 hour as tolerated

FREQUENCY:

- ☐ Induction to be completed at week 0, week 2, and week 6, and then every 8 weeks thereafter
- ☐ Maintenance every 8 weeks
- ☐ Infuse every _____ weeks

SPECIAL/LAB ORDERS:

☐ _____

_____

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 and TB infection and reactivation as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ 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	