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)		K60.3___ - Anal Fistula
	K51.8___ - Other Ulcerative (chronic) Colitis		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	TB screening
6	HBV screening/labs as required by payor

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

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

Drug			
Diphenhydramine	25mg	50mg	
Methylprednisolone	40mg	125mg	Other:
Famotidine	20mg	40 mg	
Other:			

PO

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

DRUG PRODUCT:

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

☐ **Biosimilar may be used according to payer guidelines**

If selected, prescriber must sign substitution permitted line

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 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	