



**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 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:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> 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	<b>REQUIRED:</b> TB screening for new start patients
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:
<b>IF ORDER CHANGE:</b>	
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
Famotidine		20mg	40mg		
Diphenhydramine		25mg	50mg		
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"/>	Renflexis

**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"/>	
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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:

<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	