Palmetto INFUSION®

Fax: 1-866-872-8920

IN HOME INFUSION

In-Home Referral Date:

☐ New referral ☐ Order change ☐ Order Renewal

Infliximab Unspecified Plan of Treatment for Gastroenterology

PATIENT DEMOGRAPHICS:

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

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

☐	K50.0___- Crohn's Disease (small intestine)	☐	K51.0___- Universal Ulcerative (chronic) Pancolitis
☐	K50.1___- Crohn's Disease (large intestine)	☐	K51.8___- Other Ulcerative (chronic) Colitis
☐	K50.8___- Crohn's Disease (small & large intestine)	☐	K60.3___- Anal Fistula
☐	K51.5___- Left Sided Ulcerative (chronic) Colitis	☐	_____- Other:_____

REQUESTED DOCUMENTATION:

1 Insurance information. Medication List.
2 H&P including tried and failed therapies
4 **Required:** TB for new start patients

HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE? Yes or No

REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF ORDER CHANGE: Continue current order until insurance approved

☐ Last Infusion Date:
Next Infusion Date:

HOME SUPPLY ORDER:

All supplies for vascular access, line care, dressing kit, drug administration, adverse reaction kit, infusion pump, IV pole, etc. will be provided.

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.

☑ **Home Anaphylaxis Kit:** Dispense and administer for mild and severe reaction.

2 - Epinephrine 1 mg/ml 1 ml
2 - Diphenhydramine 50 mg/ml 2 ml vial
Syringes, needles and 0.9% Normal Saline Flushes 10 mls to administer
Complete Home Infusion Physician Standing Order for complete Home Infusion, Nursing, and Adverse Reaction Orders to be utlized in the event of an adverse reaction/anaphylaxis. Epinephrine administered IM per weight based dosing guide and Benadryl 25-50mg IVP to be administered by clinician in the home.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

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

MEDICATION:

☐ Remicade
☐ Avsola
☐ Inflectra
☐ Renflexis

☐ Any infliximab biosimilar may be used according to payer guidelines

DOSE:

☐ 5mg/kg IV over 2 hours
☐ 7.5mg/kg IV over 2 hours
☐ 10mg/kg IV over 2 hours

Infliximab doses <1000mg in 250ml NS, doses >1000mg in 500ml NS, doses >2000mg in 1000ml NS (max concentration=4mg/ml)

FREQUENCY:

☐ **Induction** to be completed at week 0, week 2, week 6, and then every 8 weeks thereafter
☐ Maintenance every 8 weeks
☐ Infuse every _____ weeks
☐ May run over 1 hour as tolerated

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 PIV/Access per PIV/PICC/CVC protocol.

Dispense and Administer as Prescribed

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	