Referral Status:			MRN:
☐ New referral	☐ Order change	☐ 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. **REQUIRED:** TB screening for new start patients
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

Medication			
Diphenhydramine	☐ 25mg	☐ 50mg	
Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:
Famotidine	☐ 20mg	☐ 40 mg	
Other:	☐		

PO

Medication				
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 protocol to run over 1 hour as tolerated**

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

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
- ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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	

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- ☐ **Patient demographics - address, phone number, SS#, etc.**
- ☐ **Insurance information - copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com