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 Rheumatology

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)

☐	M05.____-Rheumatoid Arthritis with Rheumatoid factor	☐	D86.0____-Sarcoidosis of the Lung
☐	M06.____-Rheumatoid Arthritis without Rheumatoid factor	☐	L40.5____-Psoriatic Arthropathy
☐	M45.____-Ankylosing Spondylitis		
☐	____-Other:_____		

REQUESTED DOCUMENTATION:

1	Insurance information. Medication List.	REQUIRED WASHOUT FROM PREVIOUS THERAPY:	
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

IF ORDER CHANGE: Continue current order until insurance approved

☐ Last Infusion Date:

Next Infusion Date:

HOME SUPPLY ORDER:

Dispense infusion pump (CADD or Curlin) E0781, IV pole, infusion supplies A4221, tubing, administration set, infusion catheters A4211.

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

MEDICATION:

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

DOSE:

- ☐ 3mg/kg over 2 hours
- ☐ Other:_____
- ☐ May utilize expedited infusion per protocol to run over 1 hour as tolerated.

☐ **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 PIV/Access per PIV/PICC/CVC protocol.

Dispense as Written 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	

IN-HOME INFUSION PHYSICIAN STANDING ORDERS

(CHECK ALL APPLICABLE ORDERS)

Prescriber Office:	**Phone:**	
Patient Name:		**DOB:**
Address:		
City, State:	**Phone:**	**Zip:**

PRESCRIPTION

By signing below, I authorize the administration of flush medications and their associated instructions to our patients. This authorization applies as relevant to the type of access device being utilized. The validity of this order extends for one year from the date of signing.

SKILLED NURSING

A skilled nurse is authorized to assess, administer, and/or provide self-administration education as appropriate. The nurse will offer ongoing support as required. Additionally, all vascular access and ancillary orders mentioned within may be refilled as directed for a duration of one year unless discontinued prior.

VASCULAR ACCESS & ANCILLARY ORDERS

☐ Peripheral:
- ☐ Insertion of 22 or 24 gauge peripheral IV as required for ordered infusion therapy.
- ☐ 0.9% sodium chloride 5 ml pre- and post-infusion.
- ☐ 0.9% sodium chloride 10 mL pre- and post-infusion.
- ☐ Other: _____

☐ Peripheral-Midline, PICC and Central Tunneled and Non-Tunneled:
- ☐ Access peripheral-midline, PICC, or central tunneled catheter as required.
- ☐ 0.9% sodium chloride 5ml pre- and post-infusion. (5 mL pre-lab draw).
- ☐ 0.9% sodium chloride 10mL pre- and post-infusion. (10 mL pre-lab draw).
- ☐ Heparin (10 unit/mL) 5 mL post-use for flush/locking procedure

For maintenance flushing/locking:
- ☐ 10 mL of 0.9% sodium chloride followed by 5 ml Heparin (100 unit/mL)
- ☐ Other: _____

☐ Implanted Port:
- ☐ Access the implanted port as required.
- ☐ 0.9% sodium chloride 5ml pre- and post-infusion. (5 mL pre-lab draw).
- ☐ 0.9% sodium chloride 10mL pre- and post-infusion. (10 mL pre-lab draw).
- ☐ Heparin (10 unit/mL) 5 mL post-use for flush/locking procedure

For maintenance flushing/locking:
- ☐ 10 mL of 0.9% sodium chloride followed by 5 ml Heparin (100 unit/mL)
- ☐ Other: _____

CATHETER OCCLUSION ORDERS

Cathflo Activase- Instill into the occluded catheter. Let dwell for 30 minutes before attempting to aspirate. Dwell time not to exceed 120 minutes.

☐ 1 mg (midlines or patients <30 kg) ☐ 2 mg ☐ **May repeat x 1 dose.**

ANAPHYLAXIS ORDERS

MILD REACTION – Pruritis or rash, dizziness without blood pressure change, arthralgia, headache, nausea

1. Stop Infusion and connect 5-10 ml syringe and draw back to a blood return to remove the existing drug in the line and discard. Flush line with 10 ml of 0.9% sodium chloride.
2. **Diphenhydramine IV**:
   Dose:
   - ☐ 10 to 30 kg(22-66lbs) or (2-12 years old), 0.5ml (25mg) IV
   - ☐ >30 kg (>66lbs) or over the age of 12 years old, 0.5 ml (25mg) IV
   - ☐ >30 kg (>66lbs) or over the age of 12 years old, 1ml (50mg) IV
3. May repeat x **1 Dose**. (Maximum Adult Daily Dose 300mg/day)

Monitor vital signs at 15-minute intervals. If patient is back to baseline after 30 minutes, then restart the infusion. If patient is not back at baseline and symptoms persist, continue to monitor, and reassess for 15 additional minutes and to include vitals with each 15-minute interval. When patient is back to baseline restart infusion as tolerated. If mild symptoms persist, call primary ordering physician for guidance to continue to discontinue therapy.

SEVERE REACTION/ANAPHYLAXIS- Urticaria, hypotension, chest pain, shortness of breath, stridor, wheezing, vomiting, severe abdominal or back pain.

1. Stop Infusion and connect 5-10 ml syringe and draw back to a blood return to remove existing drug in the line and discard. Flush line with 10ml of 0.9% sodium chloride. Call EMS 911.
2. **Epinephrine IM Injection: (**Do Not Delay Epinephrine in favor of other drugs/adjunctive therapies.)
   - ☐ Epinephrine IM Injection: **0.15ml/ 0.15mg, 5 to 30 kg (Children, 33 to 66 lbs.)** (Preferably thigh)
   - ☐ Epinephrine IM Injection**: 0.3 ml/0.3mg, >30 kg (patients weighing > 66 pounds)**
   - ☐ If there is no response or an inadequate response, a second Epinephrine dose may be administered at 5 to 15 minutes after initial injection. Intramuscular injection is given into the mid-outer thigh.

Prescriber Signature:			**Date:**
Authorizing Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	