

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 Rheumatology

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)

M05._____ - Rheumatoid Arthritis with Rheumatoid factor	D86._____ - Sarcoidosis
M06._____ - Rheumatoid Arthritis without Rheumatoid factor	L40.5_____ - Psoriatic Arthropathy
M45._____ - Ankylosing Spondylitis	_____ -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 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	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

SPECIFIC MEDICATION:

<input type="checkbox"/>	Remicade
<input type="checkbox"/>	Avsola
<input type="checkbox"/>	Inflectra
<input type="checkbox"/>	Renflexis

Any infliximab biosimilar may be used according to payer guidelines

DOSE:

<input type="checkbox"/>	3mg/kg diluted in NS infused IV per step protocol over 2 hours
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	May utilize expedited infusion per 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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Infliximab doses <1000mg in 250ml NS, doses >1000mg in 500ml NS, doses >2000mg in 1000ml NS (max concentration=4mg/ml)

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.

<input checked="" type="checkbox"/>	Refills x 12 months unless noted otherwise here:
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LINE USE/CARE ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/>	Start PIV/Access CVC
<input checked="" type="checkbox"/>	Flush device per facility standard flushing procedure
<input checked="" type="checkbox"/>	Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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