Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Infliximab Unspecified Plan of Treatment for Dermatology

Rev 4.30.25

PATIENT DEMOGRAPHICS:

Patient Name:

Patient's Phone: 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:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** TB screening for new start patients		☐ **Continue current order until insurance approved**
6	HBV screening/labs as required by payor		

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:

☐ Remicade
☐ Avsola
☐ Inflectra
☐ Renflexis

☐ **Any infliximab biosimilar may be used according to payer guidelines**

DOSE:

☐ 5mg/kg diluted in NS infused IV 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.

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