



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

Infliximab Unspecified Plan of Treatment for Gastroenterology

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

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)

K50.0 - Crohn's Disease (small intestine)	K51.5 - Left sided Ulcerative (chronic) Colitis
K50.1 - Crohn's Disease (large intestine)	K51.0 - Universal Ulcerative (chronic) Pancolitis
K50.8 - Crohn's Disease (small & large intestine)	K51.8 - Other Ulcerative (chronic) Colitis
K50.9 - Crohn's Disease, unspecified	K60.3 - Anal Fistula
K63.2- Fistula of Intestine	- Other:

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE: <div style="border: 1px solid black; padding: 5px; text-align: center;"> Continue current order until insurance approved </div>
5	REQUIRED: TB screening for new start patients	THERAPY:	
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/RATE:

<input type="checkbox"/>	5mg/kg diluted in NS infused IV 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, week 6, and then every 8 weeks thereafter
<input type="checkbox"/>	Maintenance every 8 weeks
<input type="checkbox"/>	Infuse every _____ weeks

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

SPECIAL/LAB ORDERS:

<input type="checkbox"/>	_____
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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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NURSING 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