LIFE SPECIALTY SOLUTIONS

INFLIXIMAB

(Including Remicade and biosimilars: Inflectra, Renflexis, Avsola)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Medication List 5. Tried/Failed Therapies
6. Negative TB Results

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified without complications
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.90 Ulcerative colitis, unspecified without complications
☐ M06.9 Rheumatoid arthritis, unspecified
☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS (Please circle or check off)

☑ Optional: ☐ **Acetaminophen** 650mg PO / IV, ☐ **Diphenhydramine** 25mg PO / IV, ☐ **Methylprednisolone** 40mg IV 30 minutes prior to infusion

Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Infliximab IV

*Remicade or biosimilar (Inflectra, Renflexis, Avsola) may be used according to payer guidelines

*To prohibit auto-substitution, please indicate specific brand required _____

☐ 3mg/kg (____mg) ☐ 5mg/kg (____mg) ☐ 10mg/kg (____mg) ☐ Fixed dose ____mg/kg (____mg) every _____ weeks ☐ Other: _____	**Frequency** At weeks 0, 2, 6, and every 8 weeks thereafter FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

*Initial calculated dose will become fixed dose throughout treatment. Check here to adjust dose per appointment ☐

*Dose will be rounded to nearest vial size (See realinfusions.com for rounding protocol). To prohibit dose rounding, check here ☐

*Patient eligible for 1 hour infusions after 6 consecutive treatments without reaction. To prohibit rapid infusion, check here ☐

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE