# Infliximab

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

Advanced Infusion Care Centers

## PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

## PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complication
☐ K50.90 Crohn's disease, without complication
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.90 Ulcerative colitis, unspecified, without complications
☐ L40.0 Psoriasis vulgaris
☐ L40.50 Arthropathic psoriasis, unspecified
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ Other: _____

## PRESCRIPTION

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

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

☐ Infliximab 3mg/kg IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab 5mg/kg IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab 10mg/kg IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab _____ mg/kg IV every _____ weeks

*Dose will be rounded to the nearest vial size.*

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

## REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Tried/Failed Therapies
- Most recent labs
- Negative TB results

## ANCILLARY ORDERS

### ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
- Epinephrine (weight-based dosing) PRN per protocol
- Diphenhydramine PRN per protocol
- 0.9% Sodium Chloride bolus PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

### PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended pre-medications for this infusion.
☐ Provider Prescribed: _____

### LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
☐ Other Flush Orders: Please fax other line care orders if checking this box

### LAB ORDERS—PLEASE INCLUDE FREQUENCY

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

## PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*