

INFLIXIMAB PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128

☐ **NEW PATIENT** OR
☐ **CHANGE ORDER:** ☐ Drug Change ☐ Dose Change ☐ Interval Change

Patient Name: _____ Date of Birth: _____

Phone: _____ Gender: _____

Address: _____

Allergies: _____

Height: ☐ in ☐ cm Weight: ☐ lbs ☐ kg

CLINICAL INFORMATION

Primary Diagnosis Description: _____ **ICD-10 Code:** _____

Is this the first dose? ☐ Yes
 ☐ No – date of next dose due: _____

Treatments – Tried and Failed: _____

Hepatitis B Status: Titer Date: _____
 ☐ Positive ☐ Negative

TB Status: ☐ PPD (negative) – date: _____ ☐ Active TB ☐ Unknown
 ☐ Last chest X-ray – date: _____ ☐ Other: _____
 ☐ Past positive TB infection, course taken: _____

PRESCRIPTION

Infliximab (Remicade®) or biosimilar per payer authorization refill as directed x 1 year.

Initial Dose: ☐ Infuse _____ mg/kg IV on Weeks 0, 2, and 6.

☐ Other: _____

Maintenance Dose: ☐ Infuse _____ mg/kg IV every 8 weeks.

☐ Other: _____

Dose will be rounded to the closest 100mg vial.

ANCILLARY ORDERS

Pre-Medication Orders

- ☐ Acetaminophen 650mg PO 30 minutes before infusion. *Patient may decline.*
☐ Diphenhydramine 25mg PO/IV 30 minutes before infusion. *Patient may decline.*
☐ Methylprednisolone Succinate 125mg IV push 20 minutes before infusion.
☐ Cetirizine 10mg IV 30 minutes before infusion. *Patient may decline.*
☐ Other: _____

PRN Hypersensitivity Meds:

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>3kg)

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

Prescriber Signature: _____

Date: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **NPI:** _____

City, State, Zip: _____ **Office Contact:** _____

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