

INFILIXIMAB 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: _____
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Address: _____	NPI: _____
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City, State, Zip: _____	Office Contact: _____
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