Virginia Oncology Associates
MSIC
Multispecialty Infusion Clinic

(757) 271-0969 call
(757) 466-1128 fax

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:**	