Infliximab (Remicade, Avsola, Inflectra, Renflexis)

IVX HEALTH

Provider Order Form rev. 9/27/2021

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

☑ Hepatitis B status & date (list results here & attach clinicals)
_____

☑ TB status & date (list results here & attach clinicals)
_____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

NOTE: Many payors require patients start therapy with an infliximab biosimilar.

☐ Infuse infliximab (Remicade) OR infliximab biosimilar as required by patient's insurance.
☐ Infuse the preferred product (subject to prior authorization):
☐ infliximab (Remicade) ☐ infliximab-axxq (Avsola)
☐ infliximab-dyyb (Inflectra) ☐ infliximab-abda (Renflexis)
☑ Mix in 250ml 0.9% sodium chloride, intravenous infusion over two hours (use in line filter 1.2 micron or less)
- Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ Other: _____ ☐ Round up to nearest 100mg **OR** ☐ Give exact dose
- Frequency: ☐ induction: week 0, 2, 6, and then every 8 weeks / ☐ maintenance: every 8 weeks / ☐ other: _____
- Infusion rate: 10ml/hr x 15 min
  - Increase to: 20ml/hr x 15 min, 40ml/hr x 15 min, 80ml/hr x 15 min, 150ml/hr x 30 min, 250ml/hr until infusion complete

☑ Flush with 0.9% sodium chloride at infusion completion
☐ Patient is required to stay for 30-minute observation post infusion
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

*Perform test for latent TB; if positive, start treatment for TB prior to starting treatment. Monitor all patients for active TB during treatment, even if initial latent TB test is negative. *Patients should be tested for HBV infection before initiating TNF blocker therapy, including REMICADE. For patients who test positive for hepatitis B surface antigen, consultation with a physician with expertise in the treatment of hepatitis B is recommended.

Provider Name (Print) **Provider Signature** **Date**

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

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