

# Infliximab (Remicade, Avsola, Inflectra, Renflexis) Rapid Infusion



Provider Order Form rev. 9/28/2021

## PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
<b>Patient Status:</b> <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Last Treatment Date:	Next Due Date:

## 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](http://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: \_\_\_\_\_

## SPECIAL INSTRUCTIONS

## 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 one hour (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  Give exact dose
  - Frequency:  maintenance: every 8 weeks /  other: \_\_\_\_\_
  - Infusion rate:  100ml/hr x 15 min
  - Increase to:  300ml/hr until infusion complete
- Flush with 0.9% sodium chloride at the completion of infusion
- Patient is required to stay for 30-minute observation period
- 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)

\*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. \*Patients must have completed induction series and one maintenance dose of Infliximab with no history of infusion or hypersensitivity reaction. \*If a patient at any time develops an infusion related reaction with rapid infusion, infusion and all subsequent infusions will be administered at the two-hour infusion rate. (Patients will need to be evaluated by their referring provider and cleared to receive any future rapid infusions. A new order will need to be submitted.)

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

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

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> BAY AREA: 844-899-0275   | <input type="checkbox"/> COLUMBUS: 844-627-2675     | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN: 888-615-1445   |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARRISBURG: 844-859-4235   | <input type="checkbox"/> KANSAS CITY: 844-900-1292  | <input type="checkbox"/> TAMPA: 844-946-0849        | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
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