

Infliximab (Remicade, Avsola, Renflexis) Rapid Infusion



Provider Order Form rev. 1/11/2023

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code (required): _____ ICD-10 description: _____
 NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____
Patient Status: New to Therapy 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

- TB status & date (list results here & attach clinicals)
- Hepatitis B status & date (list results here & attach clinicals)
- 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)

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
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

Many payors require patients start therapy with an infliximab biosimilar. Choose **ONE** of these two options:

- 1. Infuse infliximab (Remicade) OR infliximab biosimilar as required by patient's insurance.
- 2. Infuse this infliximab product (subject to prior authorization):

(Products include: Remicade, Avsola, and 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: induction: week 0, 2, 6, and then every 8 weeks / 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 infusion completion
- Patient is required to stay for 30-minute observation period
- 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

FAX NUMBERS

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> BAY AREA: 844-889-0275 | <input type="checkbox"/> CONNECTICUT: 860-955-1532 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> PALM BEACH: 561-768-9044 | <input type="checkbox"/> TAMPA: 844-946-0849 |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143 | <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN/AR: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> RALEIGH: 919-287-2551 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
| | <input type="checkbox"/> DAYTONA: 386-259-6096 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> SARASOTA: 941-870-6550 | <input type="checkbox"/> EAST TN: 615-425-7427 |
| | <input type="checkbox"/> FT. LAUDERDALE: 754-946-2052 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 | |