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

IVX HEALTH

Provider Order Form rev. 4/29/2022

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

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, Inflectra, 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 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)

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