

Infliximab (Inflectra)

Provider Order Form rev. 12/23/2021



PATIENT INFORMATION

Patient Name: _____ DOB: _____

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: _____

ICD-10 Code

- EM06.9 Rheumatoid Arthritis
- K51.90 Adult Ulcerative Colitis
- L40.0 Plaque Psoriasis
- L40.52 Psoriatic Arthritis
- M45.9 Ankylosing Spondylitis
- K50.90 Adult Crohn's Disease
- K50.90 Pediatric Crohn's Disease
- Other: _____

SPECIAL INSTRUCTIONS

MEDICATION ORDER

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)

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) _____ Provider Signature _____ Date _____

REQUIRED DOCUMENTATION

- Recent Office notes (along with any therapies tried and outcomes)
- Lab Results
- Insurance Cards (front and back)
- Current Medication
- Demographic Sheet
- History and Physical Report
- TB Test

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ANA (SLE)
- Comprehensive Metabolic Panel, CBC with differential w/in past 3 months