

## Infliximab and Biosimilar Products | Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**1. For new patients, please submit with form:**

- Copy of insurance card
- History & physical
- Patient demographics
- Labs/records: HBV & TB test results

**2. Patient Information**

Male Female Height: \_\_\_\_\_ in cm Weight: \_\_\_\_\_ lbs kg Allergies: \_\_\_\_\_

Is this the first dose? Yes No, date of last infusion: \_\_\_\_\_ Next dose due: \_\_\_\_\_ Line type:  PIV  PICC  Port Other

**3. Diagnosis and Clinical Information**

**ICD-10 (required):** \_\_\_\_\_

**Primary diagnosis:**  Crohn's disease  Ulcerative colitis  Rheumatoid arthritis  Plaque psoriasis  
 Psoriatic arthritis  Ankylosing spondylitis  Other: \_\_\_\_\_

**4. Prescription Information**

<b>Infliximab Product</b>	<b>No preference:</b> pharmacist to select biosimilar infliximab product based on patient specific factors and notify provider of selection Dispense as written, indicate <b>brand</b> name: _____	
<b>Dosing / Frequency</b>	<b>Loading dose:</b> <input type="checkbox"/> 3 mg/kg* IV at 0, 2 and 6 weeks <input type="checkbox"/> 5 mg/kg* IV at 0, 2 and 6 weeks <input type="checkbox"/> 10 mg/kg** IV at 0, 2 and 6 weeks <input type="checkbox"/> Other: _____	<b>Maintenance dose:</b> <input type="checkbox"/> 3 mg/kg* IV every _____ weeks <input type="checkbox"/> 5 mg/kg* IV every _____ weeks <input type="checkbox"/> 10 mg/kg** IV every _____ weeks <input type="checkbox"/> Other: _____
<small>* Doses may be rounded to nearest whole vial (100 mg) per Coastal Infusion Services Policy &amp; Procedure, unless otherwise specified  <small>**Doses of &gt;5mg/kg are contraindicated in patients with moderate or severe heart failure</small></small>		
<b>Administration</b>	Reconstitute and dilute product per manufacturer guidelines, infuse with ≤ 1.2 micron in-line filter For adult patients, first 2 infusions over 2 hours. If well tolerated, may infuse over 1-2 hours unless otherwise specified. Pediatric patients to be infused per manufacturer guidelines. Other: _____	
<b>Quantity / Refills</b>	Dispense 1 month supply; Refill x 12 months <input type="checkbox"/> Other: _____ Dispense all medical supplies necessary for infusion	

**5. Additional Orders**

RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Policy and Procedure

**Premedication:** Give 30 min prior to infusions (Note: if nothing is checked, no premedications will be given)

**Adults (or patients weighing >40kg):**

- Diphenhydramine 25-50mg PO. Patient may decline.
- Acetaminophen 325-650mg PO. Patient may decline.
- Methylprednisolone 40mg (OR \_\_\_\_\_ mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

**Pediatrics (weighing <40 kg): (may adjust with weight changes)**

- Diphenhydramine 1mg/kg PO
- Acetaminophen 15mg/kg PO
- Methylprednisolone 1 mg/kg (OR \_\_\_\_\_ mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

Other:

RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.

RN to monitor patient for at least 30 min post infusion and educate on possible side effects, allergic reactions, and when to contact physician

**6. Adverse Reaction Orders**

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders:

**7. Prescriber Information**

Prescriber Name:

Office Contact:

Address:

City:

State: Zip:

Phone:

Fax:

License #:

DEA #:

NPI:

**Physician Signature (Substitution Permitted)**

Date

**Physician Signature (Dispense as Written)**

Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. Coastal Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

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