COASTAL INFUSION SERVICES

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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

Infliximab Product	☒ **No preference**: pharmacist to select biosimilar infliximab product based on patient specific factors and notify provider of selection ☐ Dispense as written, indicate **brand** name:_____
Dosing / Frequency	**Loading dose:** ☐ 3 mg/kg* IV at 0, 2 and 6 weeks ☐ 5 mg/kg* IV at 0, 2 and 6 weeks ☐ 10 mg/kg** IV at 0, 2 and 6 weeks ☐ Other: _____ **Maintenance dose:** ☐ 3 mg/kg* IV every _____ weeks ☐ 5 mg/kg* IV every _____ weeks ☐ 10 mg/kg** IV every _____ weeks ☐ Other: _____ ** Doses may be rounded to nearest whole vial (100 mg) per Coastal Infusion Services Policy & Procedure, unless otherwise specified* ***Doses of >5mg/kg are contraindicated in patients with moderate or severe heart failure*
Administration	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: _____
Quantity / Refills	Dispense 1 month supply; Refill x 12 months ☐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 b e 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.