Rutland Regional Medical Center
www.RRMC.org | 160 Allen Street, Rutland, VT | 802.775.7111

Infliximab

(Remicade®, Avsola®, Renflexis®, Inflectra®)

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (kg): Height (cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next due date:

Insurance carrier: PA #: PA date:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐Crohn's disease: ☐ Ulcerative colitis: ☐Rheumatoid Arthritis:

☐Psoriatic Arthritis: ☐ Ankylosing Spondylitis: ☐Other:

THERAPY ADMINISTRATION *(Select one)*

☐ Infuse infliximab-axxq (Avsola) OR infliximab reference product/biosimilar as required by patient's insurance.

☐ Infuse this infliximab product (subject to prior authorization): ______________________

DOSING *(Select one)*

☐ ___________mg IV

☐ ___________mg/kg x ________kg IV = _________mg

☐ Mix in 250 mL of NS for doses ≤ 1000 mg. Mix in 500ml NS for doses greater than 1000mg.

FREQUENCY *(Choose one)*

☐ Week 0, 2, 6, and then every 8 weeks

☐ Every ______weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC w/ diff ☐ at each dose ☐ every: ________

☐ CMP ☐ at each dose ☐ every: ________

☐ Other: ___________________________________

PRE-MEDICATION ORDERS

☐ Acetaminophen ☐ 500mg / ☐ 650mg PO

☐ Cetirizine 10mg PO

☐ Famotidine 20mg ☐ PO / ☐ IVP

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Methylprednisolone ☐ 40mg / ☐ 125mg IVP

☐ Other: ___________________________________

NURSING

☐ Hold infusion and notify provider for:

- Signs/symptoms of illness or active infection/cough, night sweats, or weight loss
- Planned/recent surgical procedures or recent live vaccinations, TB, or Hep B positive.

☐ Provide nursing care and post-procedure observation per policy

☐ In the event of an infusion reaction, per RRMC Infusion Reaction Management policy, the patient may receive:

- Acetaminophen 1000 mg orally
- Epinephrine 0.5 mg IM
- Diphenhydramine 25-50 mg IV push
- Normal saline IV at 150 mL/hr
- Methylprednisolone 125 mg IV push

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)* Required

Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, biologic agent and steroids, colonoscopy or BSA of affected skin (by indication)

Required Labs: Include negative Hepatitis B within 3 years and Negative TB within 12 months.

Provider Name *(print)* **Provider Signature** **Time** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability

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White- Patient
Yellow- Medical Records

Patient Label