

INFLIXIMAB MEDICATION ORDER

Patient's Name (Last, First, Middle) _____

DOB: _____

■ **Diagnosis** Please specify the ICD10 code if using a diagnosis with a ___ noted.

- | | |
|---|---|
| <input type="checkbox"/> M06.0 Rheumatoid arthritis w/o rheumatoid factor | <input type="checkbox"/> M40.52 Psoriatic arthritis mutilans |
| <input type="checkbox"/> M06.8 Rheumatoid arthritis, other | <input type="checkbox"/> K50.90 Ulcerative colitis |
| <input type="checkbox"/> M40.0 Psoriasis vulgaris | <input type="checkbox"/> K50.9 ___ Crohn's disease (specific ICD10) |
| <input type="checkbox"/> M45. ___ Ankylosing spondylitis (specific ICD10) | <input type="checkbox"/> _____ |

■ **Details Needed for Authorization**

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Is patient concurrently being treated with any other biologic? _____
- Does the patient have an intolerance, contraindication or hypersensitivity to any of the following agents, or has tried and failed on at least one with at least 3 months of therapy? If yes, circle all that apply. They are: 6-mercaptopurine, aminosaliclates, azathioprine, corticosteroids, mesalamine, methotrexate, sulfasalazine, hydroxychloroquine, Otezla, NSAIDs and leflunomide.
- Has the patient tried another biologic immunomodulator agent that is FDA labeled for this condition?
- Will the patient be concomitantly prescribed methotrexate? _____ If not, please document contraindication or intolerance.
- If the patient has severe psoriatic arthritis or active ankylosing spondylitis, do they concomitantly also have the other? _____

■ **Infliximab Order** Select all required.

Patient's height in ft/in: _____ Patient's weight in lbs: _____

- | | | | |
|---------------------------------|------------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Avsola | <input type="checkbox"/> Inflectra | <input type="checkbox"/> Remicade | <input type="checkbox"/> Renflexis |
|---------------------------------|------------------------------------|-----------------------------------|------------------------------------|
- If a different infliximab product is preferred by the insurance carrier, or more easily obtained, it may be substituted by checking here.

Dosage and Frequency:

- Initial dose of 3mg/kg at weeks 0, 2 and 6. Administered in 250ml normal saline over 2 hours to 2.5 hours.
- Initial dose of 5mg/kg at weeks 0, 2 and 6. Administered in 250ml normal saline over 2 hours to 2.5 hours.
- Maintenance dose of 3mg/kg every 8 weeks for _____ months. Administered in 250ml normal saline over 2 hours to 2.5 hours.
- Maintenance dose of 5mg/kg every 6 weeks for _____ months. Administered in 250ml normal saline over 2 hours to 2.5 hours.
- Maintenance dose of 5mg/kg every 8 weeks for _____ months. Administered in 250ml normal saline over 2 hours to 2.5 hours.

Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

■ **Rescue Management in case of Infusion Therapy Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone Line to Contact Person: _____

STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.