pharmacy **SPECIALISTS**

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pharmacy-specialists.com

INFLIXIMAB Infusion Order

REQUIRED: Demographics & Most recent H&P, Clinical Notes, and Medication List

PATIENT INFORMATION

Patient Name		Date of Birth		Gender	☐ Male ☐ Female
Address					
Home Phone		Work Phone		Cell Phone	

INSURANCE INFORMATION: Please fax a copy of the insurance card(s) with this form (front and back)

MEDICAL INFORMATION

Weight (kg)		Height		Allergies	
Diagnosis				ICD-10	
Patient Status	☐ New to Therapy ☐ Continuing Therapy			Next Treatment Date	
Line Access	☐ Port ☐ PICC ☐ PIV Other: ______			Lumens	☐ 1 ☐ 2 ☐ 3
Required Lab Results:	☐ Negative TB within 12 months — attach results		☐ Negative Hepatitis B within 3 years — attach results		

MEDICATION ORDERS

Infliximab

☐ Infuse infliximab OR infliximab biosimilar as required by patient's insurance
**Preferred product to be determined after review of benefits

☐ If specific brand is required: Brand Name product: ______
- Prescriber must write Brand Medically Necessary for brand to be dispensed ______

Loading Dose: ☐ Infuse ______ mg/kg at weeks 0, 2, and 6
Maintenance Dose: ☐ Infuse ______ mg/kg every 8 weeks for one year
Other Ordered Dose: ☐ Infuse ______ mg/kg weeks 0, 2, and 6 and Infuse ______ mg/kg every ______ weeks for one year

Flush orders: Sodium Chloride 0.9% per protocol pre/post infusion and Heparin 10U/mL or 100U/mL per protocol PRN

ADDITIONAL ORDERS

Pre-Medication Orders:

☐ Acetaminophen 325mg, 2 tabs PO
☐ Diphenhydramine 25mg Slow IVP ☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO
☐ Solu-Medrol ______ mg IVP ☐ Solu-Cortef ______ mg IVP
☐ Other: ______

Anaphylactic Reaction Orders:

- Diphenhydramine 25mg-50mg IM/IV PRN allergic reaction (adult)
- Epinephrine 1:1000 (mg/ml) PRN severe allergic reaction (based on patient weight)
  - >30kg (>66lbs): Epinephrine 0.3mg IM or subQ; may repeat in 5-15 minutes x 1
  - 15-30kg (33-66lbs): Epinephrine 0.15 IM or subQ; may repeat in 5-15 minutes x 1

Lab Orders: ☐ Required annual TB testing ☐ Other ______

Labs to be drawn by: ☐ Home Health Nurse ☐ Referring Provider

PROVIDER INFORMATION

By signing this form and utilizing our services, the prescriber is authorizing *Pharmacy Specialists* and its employees to serve as their prior authorization and designated agent in dealing with medical and prescription insurance companies. The prescriber certifies that the use of the indicated treatment is medically necessary, and the prescriber will supervise the patient's treatment.

Prescriber Name		Signature		Date	
Prescriber NPI		Phone		Fax		Contact Person	

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