

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	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> Loading dose: <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: _____ </td> <td style="width: 50%; vertical-align: top;"> Maintenance dose: <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: _____ </td> </tr> </table> <p><i>* Doses may be rounded to nearest whole vial (100 mg) per PromptCare Policy & Procedure, unless otherwise specified</i> <i>**Doses of >5mg/kg are contraindicated in patients with moderate or severe heart failure</i></p>	Loading dose: <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: _____	Maintenance dose: <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: _____
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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 <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*)
- | | |
|--|---|
| <p>Adults (or patients weighing >40kg):</p> <input type="checkbox"/> Diphenhydramine 25-50mg PO. Patient may decline.
<input type="checkbox"/> Acetaminophen 325-650mg PO. Patient may decline.
<input type="checkbox"/> Methylprednisolone 40mg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy) | <p>Pediatrics (weighing <40 kg): (<i>may adjust with weight changes</i>)</p> <input type="checkbox"/> Diphenhydramine 1mg/kg PO
<input type="checkbox"/> Acetaminophen 15mg/kg PO
<input type="checkbox"/> 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. PromptCare has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.
 Confidential Health Information: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization and under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to who it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.