

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: _____
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.	
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 No.: _____ DEA NO.: _____ NPI: _____

Physician Signature (Substitution Permitted)

Date

Physician Signature (Dispense as Written)

Date