



## Infliximab (Remicade, Inflectra, Renflexis, Avsola) Infusion Orders

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Diagnosis (please provide ICD10 code):  Ulcerative Colitis  Crohn's Disease

Rheumatoid Arthritis  Other: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_

New Start Therapy  Continuation of Therapy Date of last dose (if applicable): \_\_\_\_\_

### Ordering Provider:

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### PRE-MEDICATION

- Acetaminophen 1000mg PO  Solu-Medrol 125mg IVP
- Diphenhydramine 25mg PO  Solu-Cortef 100mg IVP
- Ceterizine 10mg PO  Diphenhydramine 25mg IVP

### REQUIRED LABS

- TB status and date (please attach results):  
\_\_\_\_\_
- Hepatitis B status & date (please attach results):  
\_\_\_\_\_

### INFLIXIMAB ORDERS

- Infuse Remicade -OR-  Infliximab Biosimilar as required by patient's insurance

*Based on product availability and patient insurance requirements, product recommendations may be provided*

### DOSING:

- Mix in 250ml 0.9% sodium chloride, intravenous infusion over at least 2 hours
- Dose:  5mg/kg  7.5mg/kg  10mg/kg  Other: \_\_\_\_\_ Pt weight: \_\_\_\_\_

### FREQUENCY:

- Dose at weeks 0, 2, and 6, then every 8 weeks
- Maintenance dose every \_\_\_\_\_ weeks
- Other: \_\_\_\_\_

### REFILLS:

- \_\_\_\_\_  
*(if not indicated prescription will expire one year from date signed)*

### Infuse One Standing Orders:

- Provide treatment under Infuse One's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date