Infliximab (Remicade or other infliximab product as required by patient's health plan)

Infusion Order Form – Page 1 of 1

Clinic Location

☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg. 2, Suite 204, Austin, TX 78758
P: (512) 270-2104
F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Supporting clinical notes (H&P) to support primary diagnosis:
  - Patient has active moderate to severe Crohn's disease (CD)
  - Patient has active moderately to severely active Ulcerative Colitis (UC)
  - Patient has Rheumatoid Arthritis (RA)
  - Patient has Psoriatic Arthritis
  - Patient has Ankylosing Spondylitis
  - Patient has Plaque Psoriasis
- TB status & date (list results here & attach clinicals)
- Hepatitis B status & date (list results here & attach clinicals)

Orders

NURSING

☑ Nursing care per Harbor Health Nursing Procedures, Nursing Extravasation Protocol, and Harbor Health Adverse Reaction Management Protocol.

☑ Check for history and documentation for diagnosis of moderate to severe heart failure. If present, max dose is 5mg/kg

LABORATORY

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

PRE-MEDICATION

☑ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☑ famotidine 20mg ☐ PO / ☐ IV

☑ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☑ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

Orders continued on next page

Harbor Health

Infliximab (Remicade or other infliximab product as required by patient's health plan)

Date: Patient Name: DOB:

Orders, cont.

THERAPY

☑ **Infliximab** (Remicade) or infliximab biosimilar as required by patient's insurance. **Preferred product to be determined after patient's benefit investigation.

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg
☐ other:_____
☐ Round up to nearest 100mg OR ☐ Give exact dose

Frequency: ☐ Induction: week 0, 2, 6, and then every 8 weeks

Maintenance dosing: _____mg/kg
Frequency: ☐ Every 8 weeks ☐ Every 6 weeks ☐ Every ___weeks

Order Good for: ☐ 6 months ☐ 1 year ☐ Other duration _____

Infusion rate: Select one below. Patients who tolerate induction and the initial maintenance infusion without severe reaction will be eligible for 1 hour infusion.
☐ Infuse over 2 hours (standard rate)
☐ Infuse over 1 hour (when patient eligible)

☑ Flush with 0.9% sodium chloride at infusion completion

**Perform test for latent TB; if positive, start treatment for TB prior to starting treatment. Monitor all patients for active TB during treatment, even if initial latent TB test is negative. *Patients should be tested for HBV infection before initiating TNF blocker therapy, including REMICADE. For patients who test positive for hepatitis B surface antigen, consultation with a physician with expertise in the treatment of hepatitis B is recommended.*

Special Instructions

NOTES:

Provider Name (Print): Provider Signature: Date:

Harbor Health