Premier Health
Infliximab Infusion Faxed Order Form

Patient Name ____ Date of Birth __________________

Patient MRN# ____

Patient's Allergies ____

Ordering Physician___________________________ Physician's Phone/Fax #_______________/____________

Patient's Last PPD skin test: date____________ result_____________ ☐ PPD Skin Test ☐ QUANTIFERON test

Infusion Center Fax Numbers:

MVH Middletown: 513-974-5023

MVH South: 937-641-2676

MVH Troy: 937-440-4503

MVH North: 937-641-2378

MVH Greenville: 937-641-7205

PLEASE HAVE PATIENT BRING CURRENT MEDICATION LIST

Diagnosis:

☐ Other RA with RA of multiple sites M05.89

☐ Other RA with rheumatoid factor of multiple sites M05.79

☐ Regional enteritis of unspecified site K50.90 ☐ Ulcerative Colitis K51.____

☐ Ankylosing Spondylitis of multiple sites M45.0 ☐ Other Psoriasis L40.8

☐ Other: ____

PHYSICIAN ORDERS

☐ PPD Skin Test or ☐ QUANTIFERON Test
(To be done prior to initiation of therapy)

PREMEDICATIONS: (check those preferred)

☐ Acetaminophen 650 mg PO Once (90 minutes prior to infusion)

☐ Diphenhydramine 50 mg PO Once (90 minutes prior to infusion)

Suggested for history of infusion related reaction

☐ Methylprednisolone 40mg IV Once (20 minutes prior to infusion)

INFLIXIMAB:

☐ **Renflexis (infliximab-abda) (Preferred PH agent)** (HCPCS Q5104)

☐ Remicade (infliximab) (HCPSC QJ1745)

☐ Inflectra (infliximab-dyyb) (HCPSC Q5103)

☐ Avsola (infliximab-axxq) (HSPCS Q5121)

DOSE: _______ mg/kg (All doses will be rounded to the nearest 100 mg vial) or _______ mg (doses will not be rounded without a call to provider)

(Doses will be admixed in 250ml of 0.9% sodium chloride – concentrations exceeding 4mg/ml will be admixed in 500ml of 0.9% sodium chloride)

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FREQUENCY:

☐ Series: initial dose; then at 2 weeks, and at 6 weeks; and then every 8 weeks

☐ Every 8 weeks ☐ Every 6 weeks ☐ Every 4 weeks

☐ Other specified frequency

ADMINISTRATION:

☐ Approx. 2-hour infusion - Infuse at 10 ml/hr x 15 minutes, then increase to 20 ml/hr x 15 minutes, then increase to 40 ml/hr x 15 minutes, then increase to 80 ml/hr x 15 minutes, then increase to 125 ml/hr x 30 minutes, then increase to 250 ml/hr until infusion completes. Rate increases may be made if the patient tolerates the previous rate.

Pause or stop the infusion for all infusion reactions. For severe or anaphylactic reactions – discontinue the infusion. For mild to moderate reactions – restart the infusion at 10ml/hr and follow the above titrations with a max rate of 125 ml/hr.

☐ Approx. 3-hour infusion - Infuse at 10ml/hr x 15 minutes, then increase to 20 ml/hr x 15 minutes, then increase to 40 ml/hr x 15 minutes, then increase to 80 ml/hr x 15 minutes, then increase to 125 ml/hr until infusion completes. Rate increases may be made if the patient tolerates the previous rate.

Pause or stop the infusion for all infusion reactions. For severe or anaphylactic reactions – discontinue the infusion. For mild to moderate reactions – restart the infusion at 10ml/hr and follow the above titrations.

☐ Other: ___________________

<u>Infusion Reaction Protocol:</u>

√ Premier Health standard infusion reaction protocols

For Completion by Prior Authorization Team

IF THE PATIENT HAS <u>INSURANCE OTHER THAN MEDICARE OR TRADITIONAL OHIO MEDICAID</u> PRECERTIFICATION IS REQUIRED.

PLEASE OBTAIN PRECERTIFICATION AND INCLUDE AUTHORIZATION BELOW:

Precertification

Authorization #:_______________________________________ Date range: __________________ # of infusions: ___________

☐ No precertification necessary Name of person filling out this section: ___________________________

If no precert required, list name of whom you spoke with at insurance company and on what date.

Name: ________________________Company: ___________________________Date: ___________________

Provider signature____

Printed provider name____

Date________________________ Time ____________________