

Infliximab (REMICAID and biosimilars)

PROVIDERS: Please include the following information to expedite the order:

Patient demographics, insurance information, most recent visit notes, TB status, Hepatitis B status, and applicable labs

PATIENT INFORMATION

Patient: _____ DOB: _____
ICD-10 (Required): _____ Description: _____
Allergies: _____ NKDA Weight: _____ lb kg
Patient Status: New to Therapy Continuation of Therapy
Last Treatment Date: _____ Next Due Date: _____

REFERRAL STATUS New Referral Updated Order Order Renewal

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- TB status and date (list results and attach documentation)

- Hepatitis B status and date (list results and attach documentation)

- Utilize hypersensitivity protocol established by Redeemer Health Infusion Therapy Center
- Provide nursing care and observation according to Redeemer Health Infusion Therapy Center policies and procedures

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Other: _____
- Please check this box if you do NOT authorize Redeemer Health Infusion Therapy Center to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

- acetaminophen (TYLENOL) 500 mg 650 mg 1000 mg PO
- cetirizine (ZYRTEC) 10 mg PO
- loratadine (CLARITIN) 10 mg PO
- diphenhydramine (BENADRYL) 25 mg 50 mg | PO IV
- methylprednisolone (SOLU-MEDROL) 40 mg IV 125 mg IV
- hydrocortisone (SOLU-CORTEF) 100 mg IV

THERAPY ADMINISTRATION

- Infliximab
MUST SELECT PREFERRED PRODUCT. If preferred product is not covered or the insurance company requires a specific alternative, we will contact your practice.

- REMIDCAID Unbranded infliximab AVSOLA
- INFLECTRA RENFLEXIS

Dose:

- _____ mg/kg
- _____ mg

Frequency:

- weeks 0, 2, 6, and then every 8 weeks
- every 8 weeks
- every _____ weeks

Route: intravenous

Rate:

- Infuse over 2 hours (standard rate)
- Infuse over 1 hour for eligible patients

Flush: with 0.9% sodium chloride after infusion complete

Refills: No Refills 12 months _____

SPECIAL INSTRUCTIONS

Redeemer Health Infusion Therapy Center will conduct peer-to-peer review(s) on behalf of the prescribing provider for any insurance denials. If you DO NOT AUTHORIZE Redeemer Health Infusion Therapy Center to do this on your behalf, check this box.

Provider Name (Print): _____ Provider Signature (No Stamps): _____ Date: _____