HONORHEALTH

INFLIXIMAB

(Remicade or Biosimilars)

Outpatient Infusion

Order Form

Patient Name	
DOB	
Address	
Phone	

Order Status	☐ New Order	☐ Renewal	☐ Dose or Frequency Change
Allergies:			**Weight:** **Height:**
Diagnosis	☐ Rheumatoid arthritis ☐ Psoriatic arthritis ☐ Ulcerative Colitis ☐ Crohn's Disease	☐ Ankylosing spondylitis ☐ Plaque Psoriasis ☐ Pustular Psoriasis ☐ Other:	**Diagnosis Code:**
Required Information	Negative Quantiferon TB, T-spot or chest x-ray (no active disease)		Date:
	Diagnostic Hepatitis B panel		Date:
	CBC and CMP		Date:

Please include labs attached and refer to page 2 for Required Documentation

Labs	☐ Hepatic Function panel every 3 months	☐ Other:

Pre-Medications

☐ Diphenhydramine ○ PO ○ IV ○ 25 mg ○ 50 mg ☐ Acetaminophen ○ 325 mg ○ 650 mg

☐ Other:

Medication Order

☐ **Remicade (infliximab)** ☐ **Inflectra (infliximab-dyyb)** ☐ **Renflexis (infliximab-abda)** ☐ **Avsola (infliximab-axxq)**	☐ 3 mg/kg IV ☐ 5 mg/kg IV ☐ 7.5 mg/kg IV ☐ 10 mg/kg IV ☐ Other: **Dose will be rounded up to nearest 100 mg**	☐ Induction: Week 0, 2, 6, then every _____ weeks thereafter ☐ Maintenance: Every _____ weeks ☐ Other:

Remicade has several biosimilars. Certain payors may require use of a specific biosimilar. Please select allowed alternative if Remicade is not covered by payor. If more than one, note preference.

☐ Alternative(s):

Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax:

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Required Documentation

- H&P or progress note supporting diagnosis.
- Documented negative TB within 6 months of initiation.
- Chron's: Inadequate response to systemic corticosteroids
- UC: Inadequate response to systemic corticosteroids
- RA: documentation of methotrexate combination or intolerance or contraindication. Positive RF or anti-CCP
- AS: Inadequate response to two or more NSAIDs or intolerance or contraindication to two or more NSADs
- PsA: Inadequate response to another conventional synthetic drug or intolerance or enthesitis or predominately axial disease or severe disease
- PsO: Inadequate response or intolerance to UVB, PUVA or pharmacologic treatment with methotrexate, cyclosporin, acitretin or clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin.
- Medication history
- Recent labs (as above) and/or diagnostic test results