promptcare

Intake Specialist 866-776-6782
Fax: 800-815-6808
newreferral@promptcare.com

Infliximab and Biosimilar Products I Order Form

Patient Name: ____ DOB: ________________ Phone: ______________________________
Address: ____ City:______ ___________________________ State: __________ Zip: __________

1. **For <u>new patients</u>, please submit with form:**
   ☒ Copy of insurance card ☒ History & physical ☒ Patient demographics ☒ Labs/records: HBV & TB test results

2. **Patient Information**
   ☐ Male ☐Female Height: __________ in/cm Weight: ___________ lbs/kg Allergies: ____
   Is this the first dose? Yes No, date of last infusion: _____________ Next dose due: _____________ Line type: ☐PIV ☐PICC ☐Port ☐Other

3. **Diagnosis and Clinical Information**
   ICD-10 (required): _______________
   Primary diagnosis: ☐ Crohn's disease ☐ Ulcerative colitis ☐ Rheumatoid arthritis ☐ Plaque psoriasis
   ☐ Psoriatic arthritis ☐ Ankylosing spondylitis ☐ **Other**: ______________________

4. **Prescription Information**

Infliximab Product	☐ **No preference**: pharmacist to select biosimilar infliximab product based on patient specific factors and notify provider of selection ☐ Dispense as written, indicate **brand** name:____
Dosing / Frequency	**Loading dose:** ☐ 3 mg/kg* IV at 0, 2 and 6 weeks ☐ 5 mg/kg* IV at 0, 2 and 6 weeks ☐ 10 mg/kg** IV at 0, 2 and 6 weeks ☐ Other: ______________________ **Maintenance dose:** ☐ 3 mg/kg* IV every _______ weeks ☐ 5 mg/kg* IV every _______ weeks ☐ 10 mg/kg** IV every _______ weeks ☐ Other: __________________________ ** Doses may be rounded to nearest whole vial (100 mg) per PromptCare Policy & Procedure, unless otherwise specified* ***Doses of >5mg/kg are contraindicated in patients with moderate or severe heart failure*
Administration	Reconstitute and dilute product per manufacturer guidelines, infuse with ≤ 1.2 micron in-line filter For adult patients, first 2 infusions over 2 hours. If well tolerated, may infuse over 1-2 hours unless otherwise specified. Pediatric patients to be infused per manufacturer guidelines.
Quantity / Refills	Dispense 1 month supply; Refill x 12 months ☐Other: __________________________ Dispense all medical supplies necessary for infusion

5. **Additional Orders**
   ☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Policy and Procedure
   Premedication: Give 30 min prior to infusions (*Note: if nothing is checked, no premedications will be given*)

   Adults (or patients weighing >40kg):
   ☐ Diphenhydramine 25-50mg PO. Patient may decline.
   ☐ Acetaminophen 325-650mg PO. Patient may decline.
   ☐ Methylprednisolone 40mg (OR ________mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

   Pediatrics (weighing <40 kg): *(may adjust with weight changes)*
   ☐ Diphenhydramine 1mg/kg PO
   ☐ Acetaminophen 15mg/kg PO
   ☐ Methylprednisolone 1 mg/kg (OR ______mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

   ☐ Other: ____
   ☒ RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.
   ☒ RN to monitor patient for at least 30 min post infusion and educate on possible side effects, allergic reactions, and when to contact physician

6. **Adverse Reaction Orders**
   Standard anaphylaxis kit to be dispensed and dosed per protocol:
   Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: _______________________________

7. **Prescriber Information**
   Prescriber Name: ____ Office Contact: ____
   Address: ____ City: ___________________________ State: ________ Zip: __________________
   Phone: ____________________________________ Fax: _____________________________________
   License No.: _________________________________ DEA NO.: __________________________________ NPI: ______________________________

_______________________________________ _____________ _______________________________________ _______________
Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date

Confidential Health Information: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization and under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to who it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.