PRESCRIPTION ORDER FORM

# INFLIXIMAB

## (Including Remicade and biosimilars: Renflexis, Avsola)

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

### PATIENT DEMOGRAPHICS

| | |
|---|---|
| Patient Name: | Patient's Phone Number: |
| Date of Birth: | Address: |
| Allergies: See List ☐ NKDA ☐ | City, State, Zip: |
| Weight:_____lbs or _____kg | |

### REQUIRED DOCUMENTATION

- Insurance Card • History & Physical • Patient Dem • Med List • Tried/Failed Therapies • Negative TB Results • HBV • HAV

### PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecifed without complications
K51.00 Ulcerative (chronic) pancolitis without complications
K50.10 Ulcerative pancolitis without complications
Other: _____

### LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/diff & ANC:_____ ☐ LFT's at month 2 then every 3 months after ☐ Other:_____

### PRE-MEDICATIONS ( 15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO and IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP
☐ Solu-Medrol 40mg IVP ☐ Solu-Cortef 125mg IVP ☐ Tylenol 650mg PO ☐ Other: _____

### PRIMARY MEDICATION ORDER

Remicade or biosimilar (Renflexis, Avsola) may be used according to payer guidelines
To prohibit auto-substitution, please indicate specific brand required _____

☐ Infliximab 3 mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter Infuse over 2 hours
☐ Infliximab 5 mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter Infuse over 2 hours
☐ Infliximab 10 mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter Infuse over 2 hours
☐ Infliximab _____mg/kg (_____mg) IV every _____ weeks
☐ Other: _____

- Initial calculated dose will become fixed through treatment. Check here to adjust dose per appointment ☐
- Dose will be rounded to the nearest vial size (see suitelifehealth.com for rounding protocol) To prohibit dose rounding check here ☐

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

### LINE USE/CARE ORDERS

Start PIV/ACCESS CVC ☑ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

### ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy) ☐ Other: Please fax other reaction orders if checking this box

### PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

| | |
|---|---|
| Provider Name: | Office Contact:<br>Phone: |
| Address: | ☐ Fax: |
| City, State, Zip: | ☐ Email: |
| NPI **AND** License: | |

_____ Provider Signature

_____ Date