

PRESCRIPTION ORDER FORM

INFLIXIMAB

(Including Remicade and biosimilars: Renflexis, Avsola)



Central Fax: 800-504-0870

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
- CBC • LFT

PRIMARY DIAGNOSIS

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

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION) **Selected pre-medications will be given per SuiteLife protocol unless noted below**

- | | | | |
|---|--|--|--|
| ☐ Diphenhydramine 25mg PO | ☐ Pepcid 20mg PO | ☒ Cetirizine 10mg PO | ☐ Solu-medrol 40mg IVP |
| ☐ Diphenhydramine 50mg PO | ☐ Pepcid 20mg IVP | ☒ Tylenol 650mg PO | ☐ Solu-medrol 125mg IVP |
| ☐ Diphenhydramine 25mg IVP | | | ☐ Other: _____ |
| ☐ Diphenhydramine 50mg IVP | | | |

PRIMARY MEDICATION ORDER ** If necessary, Suite Life will round dose up/down according to payor guidelines**

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:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature

Date

Rev 9/25

