Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_kg \_\_\_\_\_\_\_\_\_\_\_ lbs.

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ordering Physician Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Administer:** □ **Infliximab-dyyb (Inflectra) IV** (Formulary Product)

Non-formulary Products: (*to be given if preferred agent is per contract only)*:

□ Infliximab-axxq (Avsola) IV □ Infliximab-abda (Renflexis ) □ Infliximab (Remicade)

Weight Based Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mg/kg)  *(Dose will be rounded to the nearest 10mg)*

**OR**

Fixed Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(mg)

Frequency: Every\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ weeks

**Rate: Will be administered at 125 mL/hr over 2 hr unless titration is selected**

□ Titration requested (see box below):

|  |  |
| --- | --- |
| **Infusion Rate** | **Time (min)** |
| 10 mL/hr | For 15 minutes |
| 20 mL/hr | For 15 minutes |
| 40 mL/hr | For 15 minutes |
| 80 mL/hr | For 15 minutes |
| 150 mL/hr | For 30 minutes |
| 250 mL/hr | Until end of therapy |

**Previous Reaction:** □ Yes:  *If yes, reaction symptoms:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No

Medications to be given **30 minutes prior to start of infusion:**

□ Acetaminophen 650mg PO □ Methylprednisolone 40 mg IV push

□ Diphenhydramine 25 mg PO □ Fexofenadine 60 mg PO □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assess for signs/symptoms of hypersensitivity and/or anaphylaxis:**

* If signs/symptoms of reaction, administer diphenhydramine 25mg IV push (may repeat x1 in 15 minutes) **AND** Methylprednisolone 40mg IV push
* Ondansetron 4 mg IV push x1 for nausea

**Also required from physician office:**

* History and Physical, Assessment and Plan, or Physician Office Progress Note (s)
* Insurance authorization

**Authorization # and Dates** (*from and to)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Office Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(fax order and medical record documentation to 412-942-3559)**

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time: \_\_\_\_\_\_\_\_\_\_\_\_\_**