Ascension St. Vincent's Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Infliximab (Remicade/Inflectra/Renflexis/Avsola) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	Weight	_____ kg	Allergies	☐ NKDA	☐ List: _____

Diagnosis		ICD 10 Code(s)		J Code*	CPT Code
☐ Rheumatoid Arthritis ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Psoriatic Arthritis	☐ Ankylosing Spondylitis ☐ Plaque Psoriasis ☐ Other: _____	☐ M06.00, M06.9, M05.9, M05.89 ☐ K50.90, K50.80 ☐ K51.30, K51.90 ☐ L40.53, L40.50	☐ M45.0, M45.9 ☐ L40.9 ☐ Other: _____	☐ Remicade: J1745 ☐ Inflectra: Q5103 ☐ Renflexis: Q5104 ☐ Avsola: Q5121	☐ CPT Code: _____

Labs (prior to scheduling first infusion)	Other Labs
☑ TB test, Hepatitis screening, Hepatic (Liver) Function Panel, CRP, CBC with Differential	☐ _____ ☐ _____

Nursing Orders	Pre-medications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication*			Route	Dose	Frequency	Select Treatment Type
☐	Remicade	☐	Renflexis	IVPB	☐ 3 mg/kg ☐ 5 mg/kg ☐ ____ mg/kg ☐ ____ mg (flat dose)	Once	☐ Once ☐ Induction: Week 0, 2, and 6 (total 3 doses) ☐ Maintenance: Every 8 weeks for ____ dose(s) ☐ Other: _____
☐	Inflectra	☐	Avsola				

Order Comments: Infuse through a ≤ 1.2 micron, low protein binding inline filter, over at least 2 hours. Final concentration 0.4-4 mg/mL. Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol. ***Pharmacy may substitute a biosimilar based on insurance coverage.**
Administration Instructions For the 1st dose and for patients with a history of infusion reaction: Begin infusion at 10 ml/hr for 15 minutes, then 40 ml/hr for 15 minutes, then 80 ml/hr for 15 minutes, then 150 ml/hr for 30 minutes, then 250 ml/hr until complete. For subsequent infusions, may infuse over 2 hours without titration if the patient tolerates.

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number** _____

Provider Signature		Date	
Provider Printed Name			