INFLIXIMAB Infusion

OptiMed
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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐**M** ☐**F**

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (include ICD-10 code): _____

Weight: _____ ☐lb ☐kg **Height:** _____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Patient's first dose of INFLIXIMAB? ☐Yes ☐No (If no, date of last dose: _____ Prior dose (in mg): _____)

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

_____

Date of *negative* TB test: _____ or ☐TB test pending, will fax results. **Patient is HBV negative or has been treated:** ☐Yes ☐No

Hx of kidney disease: ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____ **Hx of heart failure:** ☐Yes ☐No **Smoker?** ☐Yes ☐No

In the past year: Use of corticosteroids: ☐Yes ☐No Number of IBD-related hospitalizations in the past year: _____

Use of narcotics: ☐Yes ☐No Minimum Hgb value (g/dL) in the past year: _____

Presence of psychiatric illness: ☐Yes ☐No Other: _____

Referring provider's preferred site of care*: ☐OptiMed Infusion Center ☐Home Infusion* ☐OptiMed to determine site of care

*Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Prescription Information

Product Selection: *If no brand indicated, pharmacist to select INFLIXIMAB brand based on clinical judgement, payer coverage, and cost to patient.*

Specific INFLIXIMAB brand requested: _____

Supply Items: Must be infused through infusion set containing a sterile, non-pyrogenic, low-protein-binding filter with pore size ≤ 1.2µm.

INFLIXIMAB Dose*

☐3mg/kg ☐5mg/kg ☐7.5mg/kg ☐10mg/kg in 250mL NaCl 0.9% administered by intravenous infusion^

**Based on the clinical judgement of the pharmacist, doses may be rounded up or down to the nearest vial size (100mg) unless checked here:* ☐*

^Infusion rate to be determined by pharmacist as clinically appropriate

INFLIXIMAB Dosing Regimen	Quantity
☐**Induction Dosing:** Infuse at week 0, 2, and 6, then begin maintenance dosing.	3 doses (infusions)
☐**Maintenance Dosing:** Infuse every: ☐8 weeks ☐6 weeks ☐4 weeks ☐Other: _____	_____ doses (infusions)

Premedication(s): ☐Acetaminophen 325-650mg PO 15-30 minutes prior to infusion

☐Diphenhydramine 25-50mg PO 15-30 minutes prior to infusion

☐Other premedication(s): _____

PRN Medication(s): ☐Acetaminophen 325-650mg PO Q4 hours PRN ☐Diphenhydramine 50mg IV x1 dose PRN

☐Methylprednisolone 125mg IV x1 dose PRN ☐Other PRN medication(s): _____

Laboratory orders (subject to availability): _____

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____

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CLEAR FORM