SPECIALTY INFUSION CENTER
An Access Infusion Care Company

INFLIXIMAB ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
Address: _____ Phone: _____ Allergies: _____
City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD 10 CODE

☐ Moderate to Severe Ulcerative Colitis	ICD-10 Code: _____
☐ Moderate to Severe Crohn's Disease	ICD-10 Code: _____
☐ Rheumatoid Arthritis	ICD-10 Code: _____
☐ Ankylosing Spondylitis	ICD-10 Code: _____
☐ Psoriatic Arthritis	ICD-10 Code: _____
☐ Plaque Psoriasis	ICD-10 Code: _____
☐ Diagnosis: _____	ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ H&P and Clinical/Progress notes supporting primary diagnosis
☐ Labs and Tests supporting primary diagnosis

MEDICATION ORDERS

Initial Dosing	☐ Infliximab _____mg/kg IV at week 0, 2, 6 then every 8 weeks thereafter
Maintenance Dosing	☐ Infliximab _____mg/kg IV every 8 weeks
Alternative Dosing	☐ Infliximab _____ IV every _____ weeks
	■ Round to the nearest 100mg vial

Refills: ☐ X 6 months ☐ X 1 Year Other: _____
(if not indicated, order will expire 1 year from date signed)

Preferred Brand: ■ No Preference
☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis

■ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
■ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
■ RN to flush and lock VAD/CVAD per company protocol
Other: _____

PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion
☐ Diphenhydramine 25mg PO prior to infusion
☐ Other: _____
☐ Other: _____

EMERGENCY MEDICATIONS

■ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):
Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)
Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____
Office Phone: _____ Office Fax: _____
Prescriber Signature: _____ Date: _____

REV: 6/2025

Gaylord, MI
Phone: (989) 619-6253
Fax: (855) 857-3834

Traverse City, MI
Phone: (231) 252-0893
Fax: (855) 857-3834

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Phone: (906) 661-1088
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