InfuCare Rx®

Infliximab Enrollment Form

Fax Referral To: 877-277-9155
Phone: 877-828-3940

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: ______________ Ship To: Patient MD Office Other: ______________

PATIENT INFORMATION

Patient Name: ______________
Address: ______________
City, State, Zip: ______________
Home Phone: ______________
Cell Phone: ______________
Date of Birth: ______________ Gender: ______________
Emergency Contact: ______________ Phone: ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________
Address: ______________
City, State, Zip: ______________
Phone: ______________
Fax: ______________
DEA #: ______________ NPI #: ______________
Contact Person: ______________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ______________ ID: ______________ Group: ______________
Secondary Insurance: ______________ ID: ______________ Group: ______________
Prescription Card: ______________ ID: ______________ BIN: ______________ PCN: ______________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

M45.9 Ankylosing Spondylitis
K50.00 Crohn's Disease
L40.0 Moderate to Severe Plaque Psoriasis
L40.50 Psoriatic Arthritis
L40.59 Psoriasis with Arthropathy
M06.9 Rheumatoid Arthritis
K51.90 Ulcerative Colitis
Other: ______________

TB/PPD test: Positive Negative Date Read: ______________
CHF History? No Yes: NY Class ______________ (I-IV)
Weight: ________ kg lbs Height: _______ cm in %BSA: _____
Allergies: ______________ NKDA
Pharmacy to coordinate home health nursing visit as necessary: Yes No
Home health nursing coordination not necessary. Reason:
MD office to administer to patient
Home health nursing already coordinated

MEDICATION ORDERS

► **Orders are intiated unless crossed out.**

Administration Frequency
One dose
3 doses (at 0, 2 and 6 weeks)
Maintenance every ____ weeks
3 doses (at 0, 2 and 6 weeks) followed by infusions every ____ weeks thereafter

Dose
Pharmacist will round to the nearest 100
Give exact dose (do NOT round)
5mg per kg over at least 2 hours**
10 mg per kg over at least 2 hours**
Other: ____ mg per kg over at least 2 hours**
**Dose based on actual body weight

Administration Instructions
- ► Dilute in 250mg 0.9% NaCl to a final concentration of 0.4 to 4 mg per mL.
- ► Do not infuse other medications through the same line.
- ► Infuse over at least 2 hours. Begin at 10 mL per hr and increase rate according to infusion rate chart.

Infusion Rate	Time
10 mL per hr	For 15 minutes
20 mL per hr	For 15 minutes
40 mL per hr	For 15 minutes
80 mL per hr	For 15 minutes
150 mL per hr	For 30 minutes
250 mL per hr	Until end of therapy

To Manage Infusion Reactions:
Methylprednisolone 125mg IV x 1 dose PRN servere urticaria, pruritis or SOB (Notify Physician).
- ► Infusion Reaction Management per InfuCare Rx protocol:
  - Acetaminiphen 650mg PO Qh PRN aches or temperature increases ≥2°F.
  - Diphenhydramine 50mg IV x 1 dose PRN urticaria, prurtis or SOB.
  - Epinephrine 0.3mg IM PRN anaphylaxis may repeat in 15 minutes and call 911.

Nursing Orders:
- ► If no central IV access, RN to insert peripherial IV, rotate site every 72 to 120 hours as needed.
- ► Weight should be taken before each dose.
- ► Monitor vital signs (pulse and blood pressure) before therapy and every 15 to 30 minutes until 30 minutes after therapy.
- ► If an infusion reaction occurs, decrease rate and monitor vital signs until symptoms subside. If reaction persists or worsens, stop infusion and notify Physician.
- ► Observe patient for 30 minutes after completion of therapy.

Other: ______________

Labs:
CBC with Diff: at each dose every: ______________
Hepatic function panel: at each dose every: ______________
CRP: at each dose every: ______________
Other: ______________ every: ______________

Premedications & Other Medications
- ► Infusion supplies as per protocol
- ► Anaphylaxis Kit as per protocol

Acetaminophen _______ mg PO prior to infusion
Diphenhydramine _______ mg PO IV
250mL 0.9% NaCl for hydration
Other: ______________

Flush Protocol
- ► NaCl 0.9% 10mL
- ► Before and after infusion

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: ______________ **Date:** ______________

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