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	PRESCRIBER INFORMATION
Patient Name: ______________	Prescriber Name: ______________
Address: ______________	Address: ______________
City, State, Zip: ______________	City, State, Zip: ______________
Home Phone: ______________	Phone: ______________
Cell Phone: ______________	Fax: ______________
Date of Birth: __________ Gender: __________	DEA #: __________ NPI #: __________
Emergency Contact: __________ Phone: __________	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 Arthropathic Psoriasis
L40.59 Psoriasis with Arthropathy
M06.9 Rheumatoid Arthritis
L50.59 Other Psoriatic Arthropathy
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

Infliximab (Remicade®) *or* Infliximab-dyyb (Inflectra®) *or* Infliximab-axxq (Avsola®) *or* Infliximab-abda (Renflexis®)

Administration Frequency

Dosing: Pharmacist will round to the nearest 100mg vial. Dose is based on actual body weight. Refill as directed for 1 year.
5mg per kg at 0, 2, 6 weeks followed by every ____ weeks thereafter. Infuse over at least 2 hours.
10mg per kg at 0, 2, 6 weeks followed by every ____ weeks thereafter. Infuse over at least 2 hours.
Maintenance every ____ weeks. Infuse over at least 2 hours.

To Manage Infusion Reactions:

- ► Infusion Reaction Management per pharmacy protocol:
- 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.
- ► 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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