

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 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
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MEDICATION ORDERS

Infliximab *or* 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, pruritis 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 peripheral 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: _____

<p>Premedications & Other Medications</p> <ul style="list-style-type: none"> ▶ Infusion supplies as per protocol ▶ Anaphylaxis Kit as per protocol Acetaminophen _____ mg PO prior to infusion	<p>Flush Protocol</p> <ul style="list-style-type: none"> ▶ NaCl 0.9% 10mL ▶ Before and after infusion Diphenhydramine _____ mg PO IV 250mL 0.9% NaCl for hydration Other: _____
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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: _____