



INFLIXIMAB REFERRAL & ORDER SET

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

PATIENT INFORMATION

PATIENT NAME		DATE OF BIRTH	PHONE
ADDRESS		CITY / STATE / ZIP	HEIGHT
WEIGHT (dosing is mg/kg)	ALLERGIES ☐ NKDA — or list:		PATIENT STATUS ☐ New ☐ Continuing

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	PHONE	FAX	NPI #
PRACTICE / OFFICE CONTACT		EMAIL	NEXT TREATMENT DATE
PRIMARY INSURANCE		POLICY #	GROUP #

CLINICAL INFORMATION ICD-10 required

☐ K50.90 Crohn's disease, unspecified	☐ K50.00 Crohn's, small intestine	☐ M06.09 Rheumatoid arthritis, multiple sites	☐ M45.9 Ankylosing spondylitis
☐ K51.90 Ulcerative colitis, unspecified	☐ K51.00 Ulcerative pancolitis	☐ L40.50 Psoriatic arthritis	☐ L40.0 Plaque psoriasis ☐ Other below
OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION		FIRST INFLIXIMAB DOSE? ☐ Yes ☐ No
DATE OF FIRST DOSE	DATE OF LAST DOSE	CURRENT DOSE, IF CONTINUING	

REQUIRED SCREENING TB and hepatitis B screening must be documented before the first dose

Hepatitis B	☐ Negative ☐ Positive ☐ Unknown Titer date: _____ ☐ Results attached
TB status	☐ PPD negative — date: _____ ☐ QuantiFERON or T-Spot — result / date: _____ ☐ Chest x-ray — date: _____ ☐ Past positive TB, course taken: _____ ☐ Active TB ☐ Unknown ☐ Other: _____ ☐ Results attached

INFLIXIMAB PRESCRIPTION

Product	☐ Infliximab biosimilar (Inflectra, Avsola, Renflexis, or as the patient's plan requires) ☐ Remicade (reference infliximab)
Initial dose	☐ Infuse _____ mg/kg IV at weeks 0, 2 and 6 ☐ Other: _____
Maintenance	☐ Infuse _____ mg/kg IV every _____ weeks (usual: every 8 weeks). Refill as directed × 1 year. ☐ Other: _____
Infusion rate	Standard: flat rate over 2 hours. If the patient has a history of infusion reaction, a titrated rate is used. Dose is rounded to the nearest 100 mg vial. Accelerated (optional): after 4 consecutive lifetime doses without reaction, may reduce to 1 hour — 100 mL/hr × 15 min, then up to 300 mL/hr × 45 min. Doses over 1,000 mg use 500 mL volume at 200 mL/hr × 15 min, then up to 600 mL/hr × 45 min. ☐ Decline accelerated infusion ☐ Other rate: _____

Before you send: most plans require a specific infliximab biosimilar and will deny the reference product. Leaving the biosimilar box checked lets us dispense whichever product the patient's plan prefers, which is the fastest route to approval.

ANCILLARY ORDERS

Premedication	☐ Acetaminophen 650 mg PO 30 min before infusion ☐ Diphenhydramine 25 mg PO 30 min before infusion ☐ Other: _____
Anaphylaxis kit standing order	Epinephrine 0.3 mg (over 30 kg), 0.15 mg (15–30 kg) or 0.01 mg/kg (under 15 kg) SUBQ or IM × 1; repeat × 1 in 5–15 min PRN. Diphenhydramine 25 mg (over 30 kg) or 1.25 mg/kg (30 kg or under, max 25 mg) IV or IM; repeat × 1 in 15 min PRN. 0.9% Sodium Chloride 500 mL (over 30 kg) or 250 mL IV at KVO rate PRN anaphylaxis.
IV flush standing order	Peripheral: 0.9% Sodium Chloride 2–3 mL pre- and post-use. Implanted port: 0.9% Sodium Chloride 5–10 mL pre/post-use, 10–20 mL pre/post lab draw; heparin 100 unit/mL 3–5 mL post-use, and every 24 hr if accessed or weekly to monthly if not.
Labs	☐ No labs ordered at this time ☐ Other: _____ Drawn by: ☐ LIVbetter ☐ Referring provider
Attach	☐ Insurance cards ☐ Clinical notes ☐ Medication list ☐ TB screening result ☐ Hepatitis B result

PRESCRIBER ATTESTATION & SIGNATURE Required — we cannot schedule without it

I certify that the treatment ordered above is medically necessary and that I will be supervising the patient's treatment. A skilled nurse may assess, administer and provide ongoing support via the access device indicated. Refill the ancillary orders as directed × 1 year. I authorize LIVbetter Infusions to secure prior authorization and submit claims to the patient's insurance.

PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes