Infliximab *(Remicade or other infliximab product as required by patient's health plan)*

Fax to 505-420-4848 or Email to refer@optimuminfusion.com

Optimum INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ TB status & date (within 6 months; attach clinicals)
_____

☑ Hepatitis B status & date (within 6 months; attach clinicals)
_____

☑ Provide nursing care per Optimum Infusion Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

Required: *CBC & CMP results must be dated within 6 months of the referral*

☐ CBC ☐ at each dose ☐ every _____ _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____ _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____ _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

Infliximab (Remicade) or other infliximab product (as required by patient's health plan)
NOTE: (Infliximab products include: Remicade, Unbranded Infliximab, Avsola, Inflectra, and Renflexis)

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg
☐ Other: _____ _____
☐ Round up to nearest 100mg **OR** ☐ Give exact dose

Frequency: ☐ induction: week 0, 2, 6, and then every 8 weeks /
☐ maintenance: every 8 weeks / ☐ other:
_____

Infusion rate: Select one below. Patients who tolerate induction and the initial maintenance infusion without severe reaction will be eligible for 1 hour infusion

☐ Infuse over 2 hours (standard rate)

☐ Infuse over 1 hour (when patient eligible)

☑ Flush with 0.9% sodium chloride at infusion completion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

*Perform test for latent TB; if positive, start treatment for TB prior to starting treatment. Monitor all patients for active TB during treatment, even if initial latent TB test is negative. *Patients should be tested for HBV infection before initiating TNF blocker therapy, including REMICADE. For patients who test positive for hepatitis B surface antigen, consultation with a physician with expertise in the treatment of hepatitis B is recommended.

Provider Name (Print) **Provider Signature** **Date**

SUBMIT ORDER FORM TO OPTIMUM INFUSION:
☐ **FAX:** 505-420-4848
☐ **EMAIL:** refer@optimuminfusion.com

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