

INFLIXIMAB (Remicade, Renflexis, Avsola, Inflectra)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List TB Test
 Clinical/Progress Notes Supporting Dx Hep B Status Results Recent lab results

Primary Diagnosis

-  ICD-10 Code (required): _____
 Rheumatoid arthritis Ulcerative colitis
 Crohn's disease Plaque psoriasis
 Psoriatic Arthritis Ankylosing spondylitis
 Other: _____

Pre-Medication

- Per violet health protocol: No recommended standard pre-medications for Infliximab
 Other: _____
 Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetrizine (Zyrtec) 10 mg PO

Therapy Administration

- Remicade OR Infliximab biosimilar may be used according to payer guidelines.** 
 IF you require a specific brand please indicate the brand required: _____

Induction:

- Infliximab 3mg/kg IV at weeks 0, 2, 6, then every 8 weeks
 Infliximab 5mg/kg IV at weeks 0, 2, 6 then every 8 weeks
 Infliximab 10mg/kg IV at weeks 0, 2, 6 then every 8 weeks

Maintenance:

- Infliximab _____ mg/kg IV every 8 weeks
 Other: _____

Refills:

- x 1 year Other: _____

- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

Lab Orders

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

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____