aleracare
advanced home infusion

HOME INFUSION ONLY

FAX 818.390.9697

InFLIXimab (Remicade, Avsola)

Provider Order Form rev. 12/23/2024

Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ K50.90 Crohn's/Pediatric Crohn's Disease
◯ K51.90 Ulcerative Colitis/Pediatric UC
◯ M06.9 Rheumatoid arthritis
◯ M45.9 Ankylosing Spondylitis
◯ L40.50 Psoriatic Arthritis
◯ L40.0 Plaque Psoriasis
◯ Other: _____

Medication Order

Remicade (inFLIXimab) ◯ Preferred Agent (only select one) ◯ Use if preferred agent is not covered by the patients insurance

Avsola (inFLIXimab-axxq) ◯ Preferred Agent (only select one) ◯ Use if preferred agent is not covered by the patients insurance

Dose:

◯ 3mg/kg (____mg) IV
◯ 5mg/kg (____mg) IV
◯ 7.5mg/kg (____mg) IV
◯ 10mg/kg (____mg) IV
◯ Other: _____
◯ Round up to nearest 100mg from dosage indicated above
◯ Give exact dose selected above

Frequency:

◯ Initiation therapy: 0, 2 and 6 weeks then every 8 weeks Qty: 3 doses
◯ Initiation therapy: 0, 2 and 6 weeks then every 6 weeks Qty: 3 doses
◯ Initiation therapy: 0, 2 and 6 weeks then every _____weeks Qty: 3 doses
◯ Maintenance therapy: Every 8 weeks Qty:1 dose
◯ Maintenance therapy: Every 6 weeks Qty:1 dose
◯ Maintenance therapy: Every _____ weeks Qty:1 dose

Note: Pharmacist will calculate infusion rates unless otherwise specified: _____

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (Negative Hep B and TB) ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Pre-Medication Order *(given 30 min before each infusion)*

acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

cetirizine (ZyrTEC) ◯ 10mg PO

loratadine (Claritin) ◯ 10mg PO

diphenhydrAMINE (Benadryl) ◯ 25mg ◯ 50mg / ◯ PO ◯ IV

methylPREDNISolone (SOLU-Medrol) ◯ 40mg IV ◯ 125mg IV

hydrocortisone (Solu-CORTEF) ◯ 100mg IV

Other: _____

Dose:_____ Route:_____ Frequency: _____

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

◯ RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

◯ Do NOT administer heparin to this patient

◯ Additional orders: _____

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Adverse Reaction and Anaphylaxis Orders

◯ Standard anaphylaxis kit (EPINEPHrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x 1; Benadryl 50 mg IV PRN for mild-moderate reactions x 1)

◯ Additional orders: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name | Provider Signature | Date

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order ◯