MEMORIAL HERMANN Pharmacy

INFLIXIMAB PRESCRIPTION REFERRAL FORM

Memorial Hermann Home Health Pharmacy
21501 Park Row Drive, Suite 210, Katy, Texas 77449 **P** 281.698.6175 **F** 281.698.6147

PATIENT INFORMATION

Please include copy of prescription and medical insurance card, front and back

Name: _____ DOB: _____ ☐ Male ☐ Female
Address: _____ City: _____ State: ____ Zip: _____
Primary Phone: _____ Alt. Phone: _____
Email Address: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

PRESCRIBER INFORMATION

Name: _____ NPI: _____ DEA: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____ Office Contact: _____

CLINICAL INFORMATION

Diagnosis (ICD-10):	☐ K50.0 - Crohn's Disease of the Small Intestine ☐ K50.1 - Crohn's Disease of the Large Intestine ☐ K50.8 - Crohn's Disease of Both Intestines ☐ K50.9 - Crohn's Disease, Unspecified	☐ K51.9 - Ulcerative Colitis, Unspecified ☐ M45.9 - Ankylosing Spondylitis, Unspecified ☐ M06.9 - Rheumatoid Arthritis, Unspecified ☐ L40.52 - Psoriatic Arthritis	☐ L40.0 - Psoriasis Vulgaris ☐ L40.9 - Psoriasis, Unspecified ☐ Other - _____

Weight: ____ kg Height: ____ cm | Date of Negative TB Test: _____ Date of Chest X-Ray: _____ | IV Access: ☐ PIV ☐ Other: _____

☐ NKDA ☐ Allergies: _____

PREVIOUS AND/OR CURRENT MEDICATIONS USED TO TREAT THIS DIAGNOSIS

Medication Name	Current	Start Date	End Date	Discontinue Reason (if stopped)
	☐			☐ Failed ☐ Other:
	☐			☐ Failed ☐ Other:
	☐			☐ Failed ☐ Other:

PRESCRIPTION AND ORDERS

Infliximab (Remicade, Inflectra, Renflexis, Avsola)

☐ No infliximab product preference ☐ Preferred Product: _____
Will this be the first dose? ☐ Yes ☐ No If NO, date of last dose: _____ Date of next dose: _____

Dosing Regimen	Dose	Frequency	Quantity/Refills
Induction dose	☐ 3 mg/kg IV ☐ 5 mg/kg IV ☐ ___ mg/kg IV	☐ Weeks 0, 2, and 6	☐ 3 doses (infusions)
Maintenance dose		☐ Every 8 weeks ☐ Every ____ weeks	☐ ___ doses (infusions) ☐ Fill until follow-up date: _____

Infusion directions: **Do not infuse any other medications along with infliximab**
☐ Start infusion at 10 mL/hr and increase if tolerated after 15 minutes. Continue to titrate the infusion as tolerated using the following infusion rates: 20 mL/hr x 15 minutes, 40 mL/hr x 15 minutes, 80 mL/hr x 15 minutes, 150 mL/hr x 30 minutes. Maximum infusion rate of 250 mL/hr. Infusion time not less than 2 hours.
☐ Other: _____

Pre-Medications
To be administered 30 minutes prior to starting the infusion

☐ Acetaminophen: ☐ 325 mg PO ☐ 500 mg PO ☐ 650 mg PO ☐ Other: _____ mg PO
☐ Diphenhydramine: ☐ 25 mg PO ☐ 50 mg PO ☐ 25 mg IV ☐ Other: _____ mg ☐ PO / ☐ IV
☐ Methylprednisolone: ☐ 40 mg IV ☐ 125 mg IV ☐ Other: _____ mg IV
☐ Other: _____

Adverse Reaction Orders

- Stop infliximab infusion.
- Call 911 as appropriate and notify prescriber immediately for any new onset of the following life-threatening hypersensitivity reactions to include fever, chills, dyspnea, pruritus, urticaria, convulsions, erythematous rash, hypotension, back pain, sudden chest pain or hypertension.
- Administer reaction management medications.
  - ☐ Diphenhydramine 25 mg IV ☐ Other: _____ mg IV PRN for urticaria, pruritus, or shortness of break
  - ☐ Acetaminophen 500 mg PO ☐ Other: _____ mg PO PRN for myalgia or fever greater than 101.3
  - ☐ Normal Saline 0.9% 500 mL at a rate of 250 mL/hr
  - ☐ Epinephrine (1:1,000 strength) 0.3 mg subcutaneously if symptoms are rapidly progressing or continue after receiving diphenhydramine
  - ☐ Other: _____

Lab Orders

☐ Albumin ☐ ALT ☐ AST ☐ Creatinine ☐ CMP ☐ CRP ☐ ESR ☐ LFT ☐ Platelets
☐ Other: _____ Frequency of Labs: ☐ Every Infusion ☐ Other: _____

Nursing Orders

Nursing to establish and/or maintain venous access, administer prescribed medication, and assess general status and response to therapy.
IV access to be flushed by nurse:
- ■ Sodium Chloride 0.9% - 10 mL pre-infusion and 10 mL post-infusion
- ■ Other: _____

Pharmacy Orders

Pharmacy to dispense flushes, needles, syringes and HME/DME quantity sufficient to complete therapy as prescribed.

By signing below, I authorize Memorial Hermann Home Health Pharmacy and its representatives to serve as my designated agent if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies.

Prescriber's Signature: _____ **Date:** _____
(Signature required – NO STAMPS)