Place Sticker Here

Infliximab (Inflectra) Treatment Plan

Patient Name: ____ DOB: _________________________

Height (cm): ______________________ Weight (kg): _________________ Allergies: ____________________

Diagnosis:

• ICD 10 Code: ______________________ Diagnosis Description: _____________________________________

Pre-Medications: **administered 30 minutes prior to infusion**

☐ None

☐ Acetaminophen 650 mg PO

☐ Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg Route: ☐ PO or ☐ IVP

☐ Methylprednisolone: Dose: ☐ 40 mg or ☐ 125 mg Route: IVP

☐ Famotidine: Dose: 20 mg Route: ☐ PO or ☐ IVPB

☐ Other (include drug, dose, and route): ____

Drug Orders:

● Infliximab-dyyb (Inflectra) (Q5103) per 250 mL Sodium Chloride 0.9% IV to infuse over 2 hours

● Dose: ☐ 3 mg/kg ☐ 5 mg/kg ☐ Other: _____ mg/kg ☐ Other: _______ mg

● Frequency: ☐ Induction: Weeks 0, 2, and 6 then every 8 weeks thereafter

☐ Maintenance: every 8 weeks

☐ Other: ____

• Order Duration: Six months unless otherwise specified (Other: _____________________________________)

Lab Orders:

☐ ____

Standing Orders:

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: ____ **Date:** ____________________________

Physician Name: ____ **Phone:** ___________________________

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months
- Provide Hepatitis screening (Hepatitis B Surface Antigen) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received infliximab at another facility, please provide last date received: ____________
- If patient has previously received another biologic therapy, please provide the name: _______________________

and the last date received: ________________

Insurance/Authorization Information:

Product Information for Authorization: Infliximab-dyyb (Inflectra) (Q5103)

If a different product is requested list name and HCPCS code: ______________________________________

Insurance Type: ____

Insurance Authorization Reference Number: ____

Date Obtained: ____________________________ Authorization Valid Until: _________________________

Additional Notes: ____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)