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.

Seacoast: 843-366-2224 (Fax)

843-366-3626 (Phone)