



Checklist for Infliximab Referral

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ NPI: _____

Referring Office Contact/Title: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ☐ Patient demographic information
- ☐ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ☐ Supporting clinical notes and office visits. Two notes preferred.
 - Note should include any therapies tried/failed, and must include discussion about Infliximab
 - Medication list and allergies
- ☐ Supporting lab reports/orders for Infliximab treatment
 - Baseline: CBC w diff, LFTs, negative Hepatitis B screening, and negative TB screening
 - *Recommended:* monitor CBC w diff and LFTs periodically with treatment
- ☐ Infliximab Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com

Email: info@infusioncenterne.com

Infusion Center of New England

18 Washington Street, Foxboro MA 02035

Ph: 781-551-5812

Fax: 508-698-8671



Prescribing Order: Infliximab

Date of Order: _____

☐ New Start ☐ Maintenance

Date of last infusion: _____

Patient Name: _____ DOB: _____ M/F: _____

Diagnosis (include ICD-10 code/s): _____

☐ NKDA Allergies: _____

Patient Weight: _____

Premedication:

- | | |
|--|--|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Diphenhydramine 25mg IV |
| <input type="checkbox"/> Loratadine 10mg or Cetirizine 10mg PO | <input type="checkbox"/> Solu-medrol 125mg IV |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Other: _____ |

Lab Orders:

- | | |
|--|---|
| <input type="checkbox"/> CBC w/diff, CMP every _____ weeks | <input type="checkbox"/> LFTs every _____ weeks |
| <input type="checkbox"/> Other: _____ | |

Infliximab Medication Order

- ☐ Infuse Remicade OR ☐ Infliximab biosimilar as required by patient's insurance
- Dosing: ☐ 5mg/kg ☐ 10mg/kg ☐ Other: _____
- Frequency: ☐ Week 0, 2, and 6 then every 8 weeks ☐ Other: _____

Administration:

- ✓ Reconstitute each 100 mg Infliximab vial with 10 mL of Sterile Water for Injection.
- ✓ Determine dose based on patient weight then dilute the required volume of the reconstituted Infliximab solution in 250 mL 0.9% Sodium Chloride.
- ✓ Infuse Infliximab over at least 2 hours with in-line 0.2 micron filter.
- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ In case of infusion reaction, STOP infusion and follow NCNE infusion reaction protocol. Notify physician.

Ordering Provider Name

NPI

Signature

Date

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