Zarina Pharmacy
SPECIALTY & INFUSION

Skip this form & e-prescribe! Select BioPlus from your EHR!

INFLIXIMAB

Fax: 832-886-4298
Phone: 832-886-4296
zarinapharmacy.com

Ship To: ☐ In Office ☐ Infusion Suite ☐ At Home ☐ Other_____

PATIENT INFORMATION

Name:	SSN:		DOB:
Address:	City:	State:	ZIP:
Home Phone:	Cell:	Gender: ◉ Female ◉ Male	
Email:	Allergies:		

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION

Diagnosis (ICD-10): _____ **Date of Diagnosis:** _____

Crohn's Disease K50.90 Plaque Psoriasis L40.9 Ulcerative Colitis K51.90 Psoriatic Arthritis L40.52 Ankylosing Spondylitis M45.9 Rheumatoid Arthritis M06.9

CHF History: ☐No ☐ Yes: NY Class ____(I-IV) **TB History:** Date of last PPD: _____ Result: ☐ Negative ☐ Positive

Comorbidities:_____

ALLERGIES: ☐ NKDA ☐ Other_____

PRESCRIPTION INFORMATION (or attach a copy of prescription)

☐ **AVSOLA®** ☐ **ENTYVIO** ☐ **INFLECTRA®** ☐ **Infliximab** ☐ **REMICADE®** ☐ **RENFLEXIS®**

☐ **Initial Dose:** _____mg/kg at week 0, 2, and 6 ☐ **Maintenance Dose:** _____mg/ kg every 8 weeks

☐ **Other:** _____mg/kg every _____ weeks **Refills**: _____

Directions:

- 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 no more than 250 mL/hr
- Infusion time should not be less than 2 hours
- DO NOT infuse any other medications along with infliximab

Vascular Access Device:

☐ Peripheral Catheter ☐ PICC ☐ Port

☐ Other (describe # of lumens): _____

Flush Orders: (If IV ordered, the following flush protocols will be followed)

☐ **Sodium Chloride 0.9%**
Peripheral Line: 3 mL before each dose and 3 mL after each dose and PRN
Central Line: 5-10 mL before each dose and 5-10 mL after each dose and PRN

☐ **Heparin 10 units/mL**
Peripheral Line: 3 mL after last sodium flush and PRN

☐ **Heparin 100 units/mL**
Central Line: 5 mL after last sodium flush and PRN

Provide needles, syringes, VAD supplies, and other ancillary supplies needed for infusion

Lab Work and Frequency:

_____
_____
_____

Pre-Medication

☐ **Diphenhydramine** 25 mg 30 min before infusion
☐ PO ☐ IVP

☐ **Acetaminophen** 650 mg tablet PO 30 min before infusion

☐ **Loratadine** _____mg PO 30 min before infusion

☐ **Other**_____ Strength:_____
Directions: _____
_____

☐ **Other**_____ Strength:_____
Directions: _____
_____

Anaphylaxis Kit Order (Infusion Reaction Management x 1/year)

☐ Epinephrine ☐ IM ☐ SUBQ Qty: _____ Refills: _____
Adult 1:1000, 0.3 mL (>30 kg/>66lbs) PRN severe allergic reaction, call 911. May repeat in 5-15 minutes as needed.

NURSING

☐ **Nursing Agency:** _____ **Phone:** _____

Skilled Nursing Visits for infliximab intravenous administration and education. To provide education related to the disease process and therapy. To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

INFUSION TYPE: ☐ **At Home** ☐ **In Office**

Prescriber Name:	Phone:	Fax:	
Office Contact:		Email:	
Address:	City:	State:	ZIP:
NPI #:		Tax ID:	
Prescriber Signature:		Date:	