VAIL HEALTH OUTPATIENT ORDERS

322 Beard Creek Rd | Edwards, CO 81632 | Ph: 970.569.7418 | Fax: 970.470.6675

Vail Health includes services of Vail Health Hospital

Infliximab Order Form

ATTACH DEMOGRAPHICS / COPY OF INSURANCE CARD, RECENT OFFICE VISIT NOTES AND TB/HEPATITIS SCREEN

Patient Name:

DOB:

Allergies/Adverse Reactions:

ICD-10:

Diagnosis:

Weight (kg):

☐ **New Start**

☐ **Continuation of therapy:**
(date next treatment due: _____)

Labs (to be drawn at each visit unless specified otherwise):

*****Results of tuberculosis and hepatitis screen MUST be attached to initial order**

☐ **AST/ALT** ☐ **CBC** ☐ **HCG urine** ☐ **Other:**

Pre-Meds:

☐ **Acetaminophen 650 mg PO**

☐ **Loratadine 10 mg PO**

☐ **Methylprednisolone 125 mg IV**

☐ **Other:**

Medication: Infliximab IV

☒ **Renflexis (preferred) or okay to sub insurance preferred biosimilar _____**

☐ **Dispense as written (drug and rationale for nonpreferred product): _____**

Dose (check one):

☐ **5 mg/kg** ☐ **10 mg/kg** ☐ **3 mg/kg**

Administration rate: Per PI or _____

Frequency:

☐ **Induction therapy: 0,2 and 6 weeks**

☐ **Maintenance therapy: every 4 weeks**

☐ **Maintenance therapy: every 6 weeks**

☐ **Maintenance therapy: every 8 weeks**

Refills (check one):

☐ **1 year** ☐ **Other: _____**

☒ **Treat hypersensitivity reaction per Vail Health Hypersensitivity Protocol**

Provider Signature: _____ **Date / Time: _____**

PRINTED PROVIDER NAME: _____ **Circle: MD / PA / NP**

Office Name: _____ **NPI: _____** **State License: _____**

Phone #: _____ **Fax #: _____**

PHO