CoxHealth at Home

Infliximab

Phone: 1-855-419-4663

Fax: 1-417-269-0692

Patient Information

Name:_____ DOB:_____

Height: _____ ❑ in ❑ cm Weight_____ ❑ kg ❑ lbs

Address:_____

_____

City:_____ State:_____ Zip:_____

Phone:_____ Alternate:_____

SSN:_____

PLEASE INCLUDE ON FAX A COPY OF FRONT AND BACK OF INSURANCE CARD(S)

Prescriber

Prescriber name:_____

NPI: _____

Address:_____

_____

City:_____ State:_____ Zip:_____

Contact:_____

Phone:_____ Fax:_____

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ K50.90 (Crohn's disease) ❑ K51.8 (Ulcerative colitis) ❑ M06.9 (Rheumatoid arthritis)

❑ L40.5 (Psoriatic Arthritis) ❑ M45.9 (Ankylosing spondylitis) ❑ Other: _____

Allergies:_____

Intravenous Infliximab (Pharmacist to select preferred biosimilar/generic/brand)

Flushing/Premedication Orders:

✓ Flushing per CoxHealth at Home protocol

- ✓ PIV: 0.9% sodium chloride 3-20mL before and after infusion as needed
- ✓ Port: 0.9% sodium chloride 3-20mL into port at time of access or at least monthly, 0.9% sodium chloride 3-20mL before and after infusion as needed, Heparin 100 units/mL 5mL as lock after infusion

Please check desired premedication below. All premedications will be given 30-60 minutes prior to infusion

Acetaminophen: ❑ 650mg by mouth ❑ Other:_____

Diphenhydramine: ❑ 50mg by mouth ❑ 25mg IV ❑ 50mg IV ❑ Other: _____

Methylprednisolone: ❑ 40mg IV ❑ Other:_____

Infliximab IV as tolerated per CoxHealth at Home protocol rate. If different rate desired, please write here: _____

Frequency:

❑ Standard loading frequency: 3 doses at weeks 0, 2 and 6 followed by infusions every 8 weeks thereafter

OR ❑ Ankylosing spondylitis loading frequency: 3 doses at weeks 0,2 and 6 followed by infusions every 6 weeks thereafter

OR ❑ Maintenance frequency: every _____ weeks

Dose: Round dose up to nearest whole vial (100mg). Dilute in 0.9% sodium chloride to a total volume of 250mL or max conc. of 4mg/mL.

❑ 3mg/kg ❑5mg/kg ❑ 10mg/kg ❑ Other _____ mg/kg

Quantity to dispense: ❑ 1 dose with 9 refills (1 year) or ❑ _____infusion(s)

Prescriber's Signature:_____ Date_____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.