Agile Infusion Services LLC
Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

REMICADE MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds*_____

■ **Diagnosis** ***Please clearly specify the ICD10 code if using a diagnosis with a ___ noted.***

☐ M06.0 Rheumatoid arthritis w/o rheumatoid factor
☐ M06.8 Rheumatoid arthritis, other
☐ M40.0 Psoriasis vulgaris
☐ M45._____ Ankylosing spondylitis (specific ICD10)
☐ M40.52 Psoriatic arthritis mutilans
☐ K51.9_____ Ulcerative colitis (specify ICD10)
☐ K50.9_____ Crohn's disease (specify ICD10)
☐ Other: _____

■ **Details Needed for Approval**

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Is patient concurrently being treated with any other biologic? _____
- Does the patient have an intolerance, contraindication or hypersensitivity to any of the following agents, or has tried and failed on at least one with at least 3 months of therapy? If yes, circle all that apply. They are: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, mesalamine, methotrexate, sulfasalazine, hydroxychloroquine, Otezla, NSAIDs and leflunomide.
- Has the patient tried another biologic immunomodulator agent that is FDA labeled for this condition?
- Will the patient be concomitantly prescribed methotrexate? _____ If not, please document contraindication or intolerance.
- If the patient has severe psoriatic arthritis or active ankylosing spondylitis, do they concomitantly also have the other? _____

■ **Infliximab IV Infusion Order** ***Select <u>all</u> required***

☐ Remicade
☐ *If a different infliximab product is preferred by the insurance carrier, or the brand selected is not procurable, it may be substituted, unless this box is checked.*

<u>Dosage and Frequency:</u>

☐ Initial dose of 3mg/kg at weeks 0, 2 and 6. Administered in 250ml normal saline over 2 hours to 2.5 hours.
☐ Initial dose of 5mg/kg at weeks 0, 2 and 6. Administered in 250ml normal saline over 2 hours to 2.5 hours.
☐ Maintenance dose of 3mg/kg every 8 weeks for _____ months. Administered in 250ml normal saline over 2 hours to 2.5 hours.
☐ Maintenance dose of 5mg/kg every 6 weeks for _____ months. Administered in 250ml normal saline over 2 hours to 2.5 hours.
☐ Maintenance dose of 5mg/kg every 8 weeks for _____ months. Administered in 250ml normal saline over 2 hours to 2.5 hours.

Utilize 1.2µ filtered tubing. *Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.*

■ **Rescue Management in Case of Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.