KAISER PERMANENTE®

Kaiser Permanente Washington Home Infusion Pharmacy (KPWAHIP)
Infliximab Prescription Referral Form
Phone: (206) 326-2990 **Fax Referral To: (206) 326-2139**

1 PATIENT INFORMATION

Patient Name: _____
Phone: _____
Address: _____
City:_____**State:**_____**Zip:**_____
MRN #: _____
DOB: _____
Drug Allergies: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
DEA#: _____**NPI:** _____
Clinic/Facility Name: _____
Address: _____
City: _____**State:** _____**ZIP:** _____
Phone: _____**Fax:** _____

3 Instructions to Provider

All orders with ✓ will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice.

4 CLINICAL INFORMATION

Diagnosis (ICD-10 code): _____ **Date of Last Dose:** _____

5 INFLIXIMAB PRESCRIPTION INFORMATION

Infliximab-dyyb (INFLECTRA) in 0.9% Sodium Chloride IV Infusion Route: Intravenous

Patient will receive infliximab-dyyb (Inflectra®) unless Infliximab (Remicade®) is otherwise specified: _____

TB Status: □ PPD (negative) Date: _____ □**Last Chest X-Ray**: Date_____ □ **Active TB:** □ **Unknown**

Weight: _____ kg Date: _____

Total Dose = _____ **mg (please round to nearest 100 mg)**

□ **Initial: Start on week 0, 2, and 6 weeks, then continue every 8 weeks thereafter**

□ **Maintenance: continue every _____ weeks thereafter**

First Dose: □ No □ Yes

Refills: □ 11 months □ Other _____ **Infusion Access:** □ PIV □ CVAD □ Other: _____

Patient's Current Home Care/Specialty Pharmacy: _____

Initial/First Dose Infusion Rate: 10-250 mL/hr titrated. Start rate at 10 mL/hr & slowly increase rate by doubling rate every 15 min. After 1 hour, increase to 150 mL/hr for 30 min, then increase to 250 mL/hr until infusion complete

Rapid Infusion Rate (60 min): Infuse over 60 min at 280 mL/hr. May be infused over 60 min if received at least 4 consecutive infliximab (or biosimilar) infusions over 2 hours with no evidence of infusion reaction. Document qualifications prior to administration of rapid infusion

Rapid Infusion Rate (30 min): Infuse over 30 min at 560 mL/hr. May be infused over 30 min if received at least 4 consecutive infliximab (or biosimilar) infusions over 1 hour with no evidence of infusion reaction. Document qualifications prior to administration of rapid infusion

Infusion Reaction Medications & Supplies

- ✓ **Hydrocortisone sodium succinate injectable 100 mg IV**
  Sig: Once PRN for hypersensitivity
- ✓ **Epinephrine Auto-Injector** □ 0.15mg □ 0.3mg **QTY**: 2
  Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use.
- ✓ **Diphenhydramine injectable 25 mg IV**
  Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath
- ✓ **Sodium Chloride 0.9% IV 250 ml Bag**
  Sig: Once PRN for anaphylaxis
- ✓ **Sodium Chloride 0.9% IV Flush**: Flush 10 ml IV before/after medication administration or as needed for line maintenance

Labs /Special Instructions/Pre-meds: _____

_____

_____

_____

Infliximab Infusion Protocol:

- Infuse per manufacturer guidelines
- Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion
- Documentation must include:
  - Start and end time of infusion
  - All rate changes, vital signs, including initial and final set
  - Patient response
- Observe patient for signs of infusion rate-related adverse reactions:
  - Blood pressure changes, increased pulse rate
  - Fever, chills
  - Headache
  - Chest, back or hip pain
  - Dyspnea
  - Mild erythema

6 PHYSICIAN SIGNATURE REQUIRED

X	X
SUBSTITUTION PERMITTED *(Date)*	DISPENSE AS WRITTEN (Date)

Members with Medicare Part B or D coverage are not required to use this form.