Remicade and Biosimilars Order Form

Phone: (877) 246-9104
Fax: (800-783-9146)
WWW.Biotekrx.com

PATIENT INFORMATION

Patient Name: _____ Date: _____

Address: _____ Phone: _____

City, State, Zip: _____

DOB: _____ Weight: _____ Height: _____ **Diabetic (Circle one):** Yes / No

Diagnosis / ICD 10 Code: _____ Allergies: _____

☐ **INITATION OF THERAPY** ☐ **CHANGE OF INTERVAL** ☐ **CHANGE OF PROVIDER**

If the patient cannot provide recent PPD results (within12 months), then perform PPD.

TUBERCULOSIS SCREENING: ☐ PPD **Date Performed:** _____ **Date Read**: _____

☐ PPD results provided by patient per Dr. _____ **Date**: _____

Result: ☐ Negative → May Initiate Remicade® Therapy

☐ Positive → ☐ Chest X-Ray performed **Date Performe**d: _____ ☐ Negative result → May initiate Remicade®

☐ Positive result → TB treatment initiated

☐ RN to teach disease management

Remicade® - Choose Regimen: ☐ **Remicade** ☐ **Avsola** ☐ **Inflectra** ☐ **Renflexis**

☐ 3 mg/kg _____ mg/NS 0.9% 250 mL or 500 mL of normal saline IV over 2 hours

☐ 5 mg/kg _____ mg/NS 0.9% 250 mL or 500 mL of normal saline IV over 2 hours

☐ 10 mg/kg _____ mg/NS 0.9% 250 mL IV over 2 hours

☐ _____mg/kg _____mg/NS 0.9% 250 mL or 500 mL of normal saline IV over 2 hours

☐ Repeat dose in 2 weeks and then every 6 weeks

Duration of Therapy: ☐ x 1 year

☐ Other: _____

☐ NS 0.9% 50 mL IVPB to flush Remicade from IV tubing

☐ Concomitant po Methotrexate _____mg/week
(Methotrexate RX given to Patient)

☐ Infuse at weeks 0,2, and 6 then every 8 weeks

☐ Other frequency:
_____

*** Start infusion at 10 mL/hr. Double the rate after 15 minutes (as tolerated) for the first hour of infusion. (After first 15 minutes → 20 mL/hr, at 30 minutes → 40 mL/hr, at 45 minutes → 80 mL/hr, at 1 hr →160 mL/hr). At 90 minutes into the infusion, the rate may be increased for the last time to a maximum rate of 250 mL/hr.**

Pre-Medications:

☐ **Diphenhydramine** _____mg, po **-or-** IV **(circle one)**, prior to start of infusion

☐ **Acetaminophen** 650 mg po prior to start of infusion

☐ **Prednisone** _____mg, po **-or-** ☐ Methylprednisolone 40 mg IVP **-or-** ☐ Hydrocortisone 100 mg IVP

☐ **Other:** _____

*** Administer pre-medications 15 to 30 minutes prior to start of infusion ***

IV Access:

☐ Start PIV if no IV access available ☐ Maintain current central line access

Catheter Care:

☐ Sodium Chloride 0.9% _____ mL IV before and after each IV access and PRN per protocol

☐ Sodium Chloride 0.9% _____ mL as above **AND** Heparin 100 Units /mL _____ mL IV flush after second saline flush and PRN

* Dressing changes weekly and PRN * Antimicrobial dressing PRN

* May obtain blood from IV access for labs * May use Cathflo 2 mg/2 mL sterile water IVP 2 mL per lumen; May repeat after 2 hours' x 1

Labs:

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ X-ray _____ ☐ Other _____

Standard Orders for Side Effects:

☐ **Promethazine** 25 mg – 1-2 tabs po q 4-6 hrs PRN nausea / vomiting

☐ **Acetaminophen** 325 mg - 2 tabs po q 4-6 hrs PRN HA, myalgia, fever

☐ **Promethazine** 25 mg IV/IM **x** 1 dose PRN nausea / vomiting

☐ **Diphenhydramine** 25 mg - 1 to 2 caps po PRN

☐ **Diphenhydramine** 25 mg **-or-** 50 mg IV **x** 1 dose PRN

☐ **Other**: _____

Monitoring Parameters:

☐ Obtain vital signs and temperature q 15 mins for the 1st hour, then q 30 mins for the remainder of the infusion

☐ Observe patient for 30 mins following the infusion

☐ Instruct patient to report symptoms of chills, fever, headache, sore throat, pain, etc.

☐ Other: _____

Anaphylactic Reaction (AR):

Epinephrine (based on patient weight)

EpiPen® Auto-injector 0.3 mg (1:1000) - Inject IM **-or-** SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins **x** 1 if necessary

EpiPen Jr® Auto-injector 0.15mg (1:2000) - Inject IM **-or-** SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins **x** 1 if necessary

Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat **x** 1 after 10 mins, if necessary

Hydrocortisone 100mg - Give 100 mg IVP **-or-** IM if no IV access

Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr

Other Orders: _____

Prescribing Physician: _____ Address: _____ Phone: _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee. Fax completed form to: (888) 963-8103 - Thank you for using BioTek reMEDys®