ArrIVe
INFUSION THERAPY

An Outpatient Department of Trinity Health Oakland
9406 Village Place Blvd, Brighton, MI 48116
Phone: 810-844-7373
Fax: 810-844-7366

Infliximab or Biosimilar

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVe Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ **Patient Address:** _____ **Patient Phone Number:** _____ **Date of Birth**: ____/____/____ **Weight:** _____kg **Height:** _____cm **Allergies:** _____	**Primary Insurance:** _____ **Member ID:** _____ **Secondary Insurance:** _____ **Member ID:** _____

Diagnosis	**Labs**	**Frequency**
☐ Rheumatoid Arthritis (M06) specified joint and laterality ICD 10: _____ ☐ Ankylosing Spondylitis (M45) ☐ Psoriatic Arthropathy (L40.59) ☐ Regional Enteritis Unspecified (K50.90) ☐ Ulcerative Enterocolitis (K51.00) ☐ Ulcerative Colitis Unspecified (K51.90) ☐ Other Diagnosis Code (ICD-10): _____ ☐ Other Indication: _____ Target start date: _____	☐ BMP ☐ CMP ☐ Hepatic Panel ☐ CBC w/diff ☐ CBC w/o diff ☐ CRP ☐ ESR ☐ Other: _____	☐ Every infusion ☐ Other: _____

Previously tried and failed therapies (include dates): _____

Infliximab or Biosimilar

Provider Note
Viral Hepatitis B & TB screening required prior to therapy initiation.

Dose	**Frequency**	
☐ 3 mg/kg ☐ 5 mg/kg ☐ 7.5 mg/kg ☐ 10 mg/kg ☐ _____ mg/kg ☐ _____ mg	**Induction** ☐ weeks 0, 2 and 6	**Maintenance** ☐ Every 6 weeks ☐ Every 8 weeks ☐ Every _____ weeks
	Date of last infusion: ____/____/____	

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Pre-Medications and Pre-Protocol (ordered at physician discretion)	☐ Acetaminophen 650 mg PO once ☐ Loratadine 10 mg PO once ☐ Diphenhydramine once ☐25 mg ☐50 mg ☐ PO ☐IV ☐ Famotidine 20 mg IV once ☐ Hydrocortisone 100 mg IV once ☐ Methylprednisolone 125 mg IVP once ☐ Other: _____	**Hydration** ☐ LR ☐ Sodium Chloride 0.9% ☐ Other _____ _____ mL at _____mL/hr ☐ Before ☐ During ☐ Following
Flushing Protocol ***as needed for line care***	☐Sodium Chloride 0.9% ☐5 mL ☐10 mL	☐Heparin 100 Units/mL ☐5 mL ☐10 mL
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary	• **Sodium chloride** 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • **Acetaminophen** 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • **Albuterol** 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • **Albuterol HFA** inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • **Epinephrine** injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • **Famotidine** injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • **Diphenhydramine** injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • **Diphenhydramine** injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • **Hydrocortisone** sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure	

Provider Name: _____ Provider Signature: _____

Attending Physician Name: _____ Provider NPI: _____

Office Phone Number: _____ Office Fax Number: _____

Note: This order is valid for 12 months from date of physician signature.

Submit