InFLIXimab Infusion Order Form

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine 04976

Diagnosis [ ] Rheumatoid arthritis [ ] Crohn's disease [ ] Ulcerative colitis, [ ] Other:

Weight: _____kg Height: _____inches [ ] New treatment
[ ] Transfer – Receiving infliximab since_____

Negative TB test date _____

- Screen for Hepatitis B infection: Hep B surface antigen, Hep B Antibody, Hep B Core Antibody total.
- Screen patient for concurrent azathioprine or mercaptopurine therapy. If patient takes either of these, contact physician regarding risk of hepatosplenic T-cell lymphoma.
- TB screen with PPD or IGRA before start of therapy if none in past 12 months. Repeat every 12 months. Notify provider of positive results.
- Obtain CBC and HFP before each dose if not done in previous 4 weeks. Hold therapy and contact physician if signs of current infection or liver disease.
- Provide patient with medication guide before administration of each dose. Allow the patient time to read and ask questions. Document process in chart.

PRE-MEDICATE (30 minutes before infusion) **or confirm patient has taken prior to arrival**

[ ] acetaminophen 1000 mg PO [ ] Other:
[ ] loratadine 10 mg PO
[ ] diphenhydramine 25 mg PO

Select one:

[ ] **InFLIXimab-dyyb (Inflectra)** – *RFGH preferred* ☐ **InFLIXimab**

_____**mg/kg** (see reverse) x _____kgs = _____mgs*(round to nearest 100mg)*

Repeat infusion: _____ then every_____weeks x _____ months
(re-order required after 12 mos.)

See page 2 for infusion instructions and monitoring.

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

Checklist for non-RFGH credentialed providers:
Annually:
[ ] H&P completed with last year **[ ]** Copy of most recent TB test result (if none, IGRA will be done in clinic)
If new therapy
[ ] Hepatitis B screen [ ] Documentation supporting diagnosis and prior therapies attached (see page 3 for required)
[ ] Problem list, current medication and allergies attached
[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist .
Contacted provider: _____

FAX to RFGH Infusion clinic at 207-858-2404 Contact Infusion Clinic at 207-858-8722

Revised: 7/8/25

Provider signature _____Date_____time_____

If not RFGH credentialed: Printed name_____ Phone # _____

RFGH Co-signature _____

Date_____ time:_____

Patient _____

Dob_____ phone #_____

INFUSION:

Time (minutes)	Infliximab naïve patients (infusions 1 thru 4)	Time (minutes)	Rapid infusion rate escalation if tolerated at least 4 infusions at slower rate.
0	10 mL/hour x 15minutes	0	20 mL/hour x 7 minutes
15	20 mL/hour x 15 minutes	7	40 mL/hour x 7 minutes
30	40 mL/hour x 15 minutes	14	80 mL/hour x 7 minutes
45	80 mL/hour x 15 minutes	21	160 mL/hour x 7 minutes
60	150 mL/hour x 30 minutes	28	300 mL/hour x 15 minutes
90	250 mL/hour until complete	43	550 mL/hour until complete

- For sudden drop in BP or increase in pulse, STOP infusion and monitor vital signs until return to baseline. Resume infusion at last tolerated rate and increase as tolerated.
- If SEVERE reaction, STOP infusion and manage per unit policy.
- Return to infliximab naïve infusion rates for all subsequent doses, if rapid escalation not tolerated.

VITAL SIGNS: Obtain and document:

- Pre-infusion
- Before each titration
- Every 30 minutes until infusion complete.

DISCHARGE:

- Educate patient about signs and symptoms of severe infections.
- Continue to observe 30-60 minutes post infusion. Patient may be discharged 30 minutes after infusion if stable they remain stable.

Revised: 4/8/25

*See next page for **DISEASE SPECIFIC DOCUMENTATION REQUIREMENTS***

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DISEASE SPECIFIC DOCUMENTATION REQUIREMENTS

	Crohn's	Rheumatoid Arthritis	Ulcerative Colitis
ICD-10 codes	K50.00 – K50.919	M06.00 - M06.39 M06.80 – M06.9	K51.00 – K51.99
Documentation requirements	Medical records should include: 1) The basis for each diagnosis made in accordance with recognized guidelines. 2) Height and weight when needed to determine appropriate dosing. 3) Evaluation for latent tuberculosis infection through medical evaluation PPD. Treatment of latent TB initiated prior to therapy with infliximab. 4) Documentation of the disease specific relevant symptoms and signs being treated and being followed to assess for response to treatment. 5) Documentation of Inadequate Response (includes lack of efficacy, adverse effects prohibiting further use of the drug or medical contraindications) to a 3 month trial of appropriately dosed and disease specific conventional (non-biologic) therapy).		
Prior concurrent therapy	Moderate to severely active Crohn's with inadequate response* to conventional therapy (e.g. corticosteroids, 5-ASA, mesalalmine, 6-mercaptopurine or azathioprine -OR- Fistulizing Crohn's disease	Moderate to severe, active RA in combination with methotrexate and an inadequate response to methotrexate. An adequate trial of methotrexate should last a minimum of three (3) months. -OR- Without concurrent methotrexate if patient is intolerant to methotrexate or for whom methotrexate is contraindicated. (documented)	Inadequate response to conventional therapy.
FREQUENCY & DOSE Limit is per FDA labelling	5 mg/kg at 0, 2, 6 weeks, then every 8 weeks. May be increased to 10 mg/kg if response lost.	3 mg/kg at 0, 2, 6 weeks, then every 8 weeks. May be increased up to 10mg/kg every 4 weeks if incomplete response.	5 mg/kg at 0, 2 ,6 weeks then every 8 weeks
Documentation of response	Presence and severity of abdominal pain, diarrhea, extra-intestinal manifestations, enterocutaneous and/or rectovaginal fistulae.		
Continued treatment	Retreatment of patients with Crohn's disease will be covered when the medical record substantiates that the patient had a reduction in the clinical signs and symptoms of the disease after the initial treatment.	Beyond 30 weeks - the medical record must include evidence of at least 20% improvement in tender joint count and at least 20% improvement in swollen joint count.	