ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER	
ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

INFLIXIMAB OR INFLIXIMAB BIOSIMILAR

Patient Name:_____ Requested Start Date: _____/_____/_____
Date of Birth:_____/_____/_____ Patient Weight: _____ kg Patient Height: _____

***DIAGNOSIS & ICD-10 CODE*:**
❑ Crohn's Disease (ICD-10: _____) ❑ Ulcerative Colitis (ICD-10: _____) ❑ Ankylosing spondylitis (ICD-10: _____)
❑ Rheumatoid Arthritis (ICD-10: _____) ❑ Psoriatic Arthritis (ICD-10: _____) ❑ Other (ICD-10: _____)

***REQUIRED*:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

REQUIRED BASELINE LABS & INFORMATION:
- ✓ CBC & CMP
- ✓ Negative Latent TB Test (Date: _____ | ❑ QuantiFERON Gold | ❑ PPD | ❑ Chest X-Ray | ❑ Other: _____)
- ✓ HBV Screening/Status (Date: _____ | HepBsAg _____ | HepBsAb _____ | HepB Core Ab _____)

ROUTINE LABS: ❑ CMP | ❑ CBC w/ diff | ❑ LFT | ❑ CRP | ❑ Trough | ❑ ESR | ❑ Other: _____
ROUTINE LAB FREQUENCY: ❑ Each Infusion | ❑ Annually | ❑ Other: _____

ACCESS: *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYM OIC P&Ps*

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

✓ **PRE-MEDICATIONS** – Give 30 minutes prior to infusion
- ❑ Acetaminophen 650 mg PO x1 ❑ Diphenhydramine 25 mg PO x1 ❑ Diphenhydramine 50 mg IV x1
- ❑ Loratadine 10 mg PO x1 ❑ Methylprednisolone sodium succinate 125 mg IV x1
- ❑ Other: _____

✓ **InFLIimab or InFLIXimab Biosimilar** per formulary/insurance (RPH USE: infliximab | abda | dyyb | axxq | _____)

DOSE: _____ mg/kg x _____ weight (kg) = _____ mg/dose – *ROUND UP TO NEAREST 100 MG*
☑ Infuse over 2-3 hours per manufacturer's instructions through appropriate in-line filter. Concentration 0.4-4 mg/mL
☑ **FAST-TRACK/RAPID INFUSION** over 1 hour allowed after 4 reaction-free doses have been administered.

✓ **FREQUENCY:**
- ❑ Induction: Weeks 0, 2, 6 then every 8 weeks ❑ Maintenance: every 8 weeks
- ❑ Other: Infuse every _____ weeks

MONITORING: Vitals at baseline and at completion of infusion.
SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 30 minutes after infusion is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions.

Provider Signature: _____ Date: _____
Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

INFLIXIMAB & INFLIXIMAB BIOSIMILARS

MultiCare
Yakima Memorial Hospital