CoxHealth at Home infliximab

PHONE: 1-855-419-4663
FAX: 1-417-269-0692

Patient Information

Patient name: _____ DOB: _____
Sex: ❑ Female ❑ Male SSN: _____
Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____ ❑cm ❑in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ ___ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ❑ First Fill ❑ Always Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ M06.9 (Rheumatoid Arthritis) ❑ K50.9 (Crohns) ❑ L40.5 (Psoriatic Arthritis)
❑ K51.8 (Ulcerative Colitis) ❑ M45.9 (Ankylosing Spondylitis) ❑ Other _____
Diagnosis Date: _____ TB test: Yes No Negative Test Date: _____

Prior Therapy Yes No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____
Concomitant Medications: _____
Allergies: _____

Prescription

Flushing Orders:
• Per CoxHealth at Home protocol
PIV: 0.9% Sodium Chloride 3-20 ml before and after infusion as needed
Port : Bacteriostatic 0.9% Sodium Chloride 3-20ml into port at time of access or at least monthly, 0.9% Sodium Chloride 3-20 ml before and after infusion and as needed, Heparin 100units/ml 5ml as lock after infusion

Pre-Medication Orders:
❑ Diphenhydramine ____ mg PO 30 minutes prior to infusion
❑ Diphenhydramine ____ mg IV in 10ml NS 15-30 minutes prior to infusion
❑ Acetaminophen 650mg PO 30 minutes prior to infusion
❑ Other: _____

infliximab:
Frequency: ❑ 3 doses at weeks 0,2 and 6 followed by infusions every ____ weeks thereafter
OR
❑ Maintenance: every ____ weeks

Dose: RPh will round up to the nearest vial size (100mg) or ❑Give the exact dose (do NOT round)
❑ 5mg/kg IV over at least 2 hours
❑ 3mg/kg IV over at least 2 hours
❑ Other_____IV over at least 2 hours

• Dilute in 250ml 0.9% Sodium Chloride to a final concentration of 0.4 to 4mg/ml
• First doses will follow CoxHealth at Home infusion rate protocol

Duration:❑ Refills x 1 year OR❑_____ infusions

LABS: ❑ with each infusion OR ❑every _____
❑ CBC with Diff
❑ Hepatic function panel
❑Serum Creatinine
❑Other: _____

Note:
• Orders are initiated unless crossed out by provider

Prescriber's Signature: _____ **Date:** _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home

CoxHealth