Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Infliximab Treatment Plan (Dermatology)

Patient Name: _____ **Patient DOB** _____

General

☐ Diagnosis- Plaque Psoriasis ICD-10 Code _____

☐ Diagnosis- Pustular Psoriasis ICD-10 Code _____

☐ Diagnosis- Other _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Authorized Treatment Duration ☐ 12 Months ☐ Other _____

***Note: Pharmacy will interchange biosimilar product per insurance approval unless box on page 4 is selected prohibiting interchange. If interchange is **NOT** allowed by provider, please indicate preferred product here:

Preferred Product: _____

☑ Pharmacy may round dose to nearest 100mg

☑ Infuse over 2 hours for the first 3 infusions. If / when patient tolerates at least three consecutive infusions over 2 hours without signs or symptoms of intolerance, hypersensitivity, or anaphylactic reaction, nursing may request pharmacy to adjust rate to run over 1 hour for subsequent infusions

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)

every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP every 30 minutes during the infusion and prior to discharge

Pre- Treatment Medications

Tylenol (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*

Comments: Administer 30 minutes before infliximab dose

Benadryl (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*

Comments: Administer 30 minutes before infliximab dose

☐ *50 mg, IV Push, Injection, Day of Tx*

Comments: Administer 30 minutes before infliximab dose

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Infliximab Treatment Plan (Dermatology)

SOLU-Medrol (Month 1 to 12)

- ☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
  Comments: Administer 30 minutes before infliximab dose
- ☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
  Comments: Administer 30 minutes before infliximab dose

☐ **Loading Dose Infliximab** (week 0,2,6)

- ☐ *3 mg/kg, IV Piggyback, Injection, Day of Tx*
  Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less
- ☐ *4 mg/kg, IV Piggyback, Injection, Day of Tx*
  Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less
- ☐ *5 mg/kg, IV Piggyback, Injection, Day of Tx*
  Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less
- ☐ *6 mg/kg, IV Piggyback, Injection, Day of Tx*
  Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less
- ☐ *7 mg/kg, IV Piggyback, Injection, Day of Tx*
  Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less
- ☐ *8 mg/kg, IV Piggyback, Injection, Day of Tx*
  Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less
- ☐ *9 mg/kg, IV Piggyback, Injection, Day of Tx*
  Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less
- ☐ *10 mg/kg, IV Piggyback, Injection, Day of Tx*
  Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Infliximab Treatment Plan (Dermatology)

☐ **Maintenance Dose Infliximab**

☐ **Every 8 weeks** ☐ **Every 6 weeks** ☐ **Every 4 weeks** ☐ **Other -Every____ Weeks**

☐ *3 mg/kg, IV Piggyback, Injection, Day of Tx*
Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less

☐ *4 mg/kg, IV Piggyback, Injection, Day of Tx*
Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less

☐ *5 mg/kg, IV Piggyback, Injection, Day of Tx*
Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less

☐ *6 mg/kg, IV Piggyback, Injection, Day of Tx*
Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less

☐ *7 mg/kg, IV Piggyback, Injection, Day of Tx*
Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less

☐ *8 mg/kg, IV Piggyback, Injection, Day of Tx*
Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less

☐ *9 mg/kg, IV Piggyback, Injection, Day of Tx*
Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less

☐ *10 mg/kg, IV Piggyback, Injection, Day of Tx*
Comments: in 250 mL NS. Administer IV over at least 2 hours with an in-line, low-protein-binding filter 1.2 µm or less

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician. Patient should be accompanied by another adult upon discharge

☑ Communication Order (Month 1 to 12)
Ensure results of Hepatitis B surface antigen testing and record results if not present in medical record. Results must be within last 12 months.

☑ Communication Order (Month 1 to 12)
Ensure negative PPD or other test to exclude latent tuberculosis. Results must be within the last 12 months.

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Infliximab Treatment Plan (Dermatology)

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing Temperature > 100 or HR <50 or > 130

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of PPD test or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of Hepatitis B surface antigen or if results are not available. Results must be within the last 12 months.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ Quantiferon(R)-TB Gold, 4T, Incu-(36971) (If Needed)
☑ Hepatitis B Surface Antibody, Qual-(499) (If Needed)
☑ Hepatitis B Surface Antigen w Ref/Conf-(498) (If Needed)
☑ Hepatitis B Core Antibody, Total-(501) (If Needed)
☑ CBC w/ Diff (If Needed)
☑ Sedimentation Rate (If Needed)
☑ C-Reactive Protein (If Needed)
☑ BUN (If Needed)
☑ ALT(If Needed))
☑ AST (If Needed)
☑ BMP (If Needed)
☑ Urinalysis with Microscopic, if indicated (If Needed)

☐ Biosimilar Substitution **NOT** permitted

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____