Troy Infusion Center
600 W Main Street
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Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629

Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
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Infliximab Order Form

Epic Referral Reference: REF115174

Patient Name: ____ **DOB:** _______________________

Address: ____

Phone: __________________________________ **ICD-10 Diagnosis:** ____________________________

Certain reference medications may be substituted with FDA approved biosimilars based upon insurance requirements and/or KHN formulary substitutions. Renflexis is the KHN preferred product. Final product is determined by these two factors – insurance requirements and preferred product.

Induction Dosing:

Infliximab IV infusion in 250mL NS: ☐ 5 mg/kg ☐ 7.5 mg/kg ☐ 10 mg/kg ☐ ______mg/kg

Renflexis (infliximab-abda) Remicade (infliximab) Inflectra (infliximab-dyyb) Avsola (infliximab-axxq)

Infuse at weeks 0, 2, and 6 followed by maintenance dosing below.

Maintenance Dosing:

Infliximab IV infusion in 250mL NS: ☐ 5 mg/kg ☐ 7.5 mg/kg ☐ 10 mg/kg ☐ ______mg/kg

Renflexis (infliximab-abda) Remicade (infliximab) Inflectra (infliximab-dyyb) Avsola (infliximab-axxq)

Frequency: ☐ Every 8 weeks ☐ Every 6 weeks ☐ Other____________________

**All doses > 1000 mg will be diluted in 500mL NS per package insert.

Order good for: ☐ 6 months ☐ 1-year Other duration: __________________________

Last date and type of TB test: _____________________________ (please fax copy of results with order)

Last date of Hepatitis B Panel: _____________________________ (please fax copy of results with order

☐ Perform annual TSPOT test at Kettering Health Infusion Center

☐ Draw Hepatitis Panel at Kettering Health Infusion Center

Pre-meds: (given at each infusion) ☐ no pre-meds

☐ Tylenol 650 mg po or ☐ Tylenol 1000 mg po

☐ Benadryl _____ mg po or ☐ Benadryl ______ mg IV

☐ Other: ____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name:____

Prescriber Full Address: ____

Office Phone Number: _________________________ **Office Fax Number:** ________________________

Prescriber Signature: ____ **Date:** ____________________