Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Infliximab or Biosimilar Infusion Order (Revised 7/3/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ K50.0____ Crohn's Disease (small intestine)	☐ K51.8____ Other Ulcerative Colitis
☐ K50.1____ Crohn's Disease (large intestine)	☐ L40.5____ Psoriatic Arthropathy
☐ K50.8____ Crohn's Disease (small and large intestine)	☐ M06.____ Rheumatoid Arthritis without rheumatoid factor
☐ K51.5____ Left sided Ulcerative Colitis	☐ M45.____ Akylosing Spondylitis
☐ K51.0____ Universal Ulcerative Pancolitis	☐ D86.____ Sarcoidosis
☐ Other:	☐ M05.____ Rheumatoid Arthritis with rheumatoid factor

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Pertinent Diagnostic Studies to Ordered Medication	☐ Yes ☐ No

Treatment Parameters:

☑ Hold Treatment and Notify Provider IF:
- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

☑ Required Lab Results: Hep B Profile and PPD/Quantiferon Gold PRIOR to FIRST treatment. (**Fax labs with order**)

☑ Hold Treatment Notify Provider IF: Hep B Panel: POSITIVE or not on file; PPD/Quantiferon Gold: POSITIVE or not on file.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.

☑ Loading Doses: Obtain vital signs PRE-treatment, AFTER first hour of treatmen, PRN during treatment, and POST-treatment.
Maintenance doses: Obtain vital signs PRE-treatment, PRN during treatment, and POST-treatment.

☑ Monitor patient for new onset or worsening congestive heart failure symptoms.

☑ If patient has an infusion reaction to infliximab and treatment is continued per provider order, the rate will be determined by the provider.

☑ Infuse using a 1.2 micron filter or less.

☑ Monitor patient for signs of reaction for 30mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 650mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg IV ONCE

☐ Loratadine (Claritin) 10mg PO ONCE

☐ Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:

☐ Loading Dose: Infliximab or biosimilar _____ mg/kg IV over 2 hours - Weeks 0, 2 and 6, then:

☐ Infliximab or biosimilar_____ mg/kg IV over 2 hours every 4 weeks	☐ Infliximab or biosimilar_____ mg/kg IV over 2 hours every 8 weeks
☐ Infliximab or biosimilar_____ mg/kg IV over 2 hours every 6 weeks	☐ Infliximab or biosimilar_____ mg/kg IV over 2 hours every ____ weeks

☑ **Atrium Health will authorize the payer preferred infliximab product unless contraindicated** (*list contraindicated infliximab product in the allergy section*)

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.

☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.

☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: