Oso Home Care, Inc.
Specialty Infusion Services

Infliximab Infusion Order Form

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Allergies: _____

Is patient pregnant? ☐ Yes ☐ No Patient's Height: _____ Patient's Weight (kg): _____

TB Test must be performed prior to starting therapy and yearly while on therapy. Date of Negative TB Test: _____

DIAGNOSIS INFORMATION:

☐ Ulcerative Colitis. Diagnosis Code: _____

☐ Crohn's Disease. Diagnosis Code: _____

☐ Rheumatoid Arthritis. Diagnosis Code: _____

☐ Other: _____

☐ Psoriatic Arthritis. Diagnosis Code: _____

☐ Plaque Psoriasis. Diagnosis Code: _____

☐ Anklylosing Spondylitis. Diagnosis Code: _____

PRE-MEDICATION

☐ Tylenol (Acetaminophen) 650 mg PO ☐ Benadryl 25 mg PO ☐ Zyrtec 10 mg PO

☐ Benadryl 25 mg slow IVP ☐ Solu-medrol slow IVP ☐ 20 mg ☐ 40mg ☐ 125mg ☐ Other: _____

☐ Other: _____

Please indicate therapy:

☐ Remicade (infliximab)

Biosimilars

☐ Inflectra (infliximab-dyyb)

☐ Renflexis (infliximab-abda)

☐ Avsola (infliximab-axxq)

Please indicate dosing:

☐ _____ mg/kg IV at weeks 0,2,6 and then every 8 weeks x 1 year.

☐ _____ mg/kg, continue IV every 8 weeks x 1 year. Last Infusion Date: _____

☐ _____ mg/kg, continue IV every _____ weeks x 1 year. Last Infusion Date: _____

IN CASE OF REACTION

Follow Oso Protocol for anaphylaxis and infusion reactions

NURSING

Oso to coordinate nursing services in Ambulatory Infusion Suite

LAB ORDER

SN to perform labs with each infusion:

☐ CBC, CMP, CRP

☐ Infliximab quant with reflex to antibodies

☐ Other: _____

_____

PHYSICIAN INFORMATION

MD Name: _____ Office Contact: _____

Address: _____

Phone: _____ Fax: _____

MD Signature: _____ Date: _____

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