

### Checklist for Inflectra (infliximab-dyyb) Referral

Required documentation for all initial referrals

Patient \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_  New Start  Maintenance

Please return **completed** checklist and checklist items for an infusion referral:

- Patient demographics (e.g. address, phone number, SSN, etc.)
- Insurance information and copy of insurance card(s). Please indicate the insurance that is primary, and the insurance that is secondary, if applicable, and the subscriber’s date of birth.
  - If insurance requires prior authorization, please provide the phone number and allow up to 15-30 days for this to be completed by one of our Infusion Coordinators.
- Signed and completed Inflectra Standard Order (our order form) with ICD diagnosis code
  - *Standard Order forms are available at [lowcountryrheumatology.com/infusions/](http://lowcountryrheumatology.com/infusions/)*
- Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy, and how long patient has been on Inflectra.
- Lab results and/or tests to support diagnosis.
  - Pre-Screening:
    - **Required TB screening results:** PPD (*within 1 year*) or QuantiFERON Gold Test (*within 3 years*)
    - **Required Hepatitis screening (*within 1 year*):** Hepatitis B Surface Antigen, Hepatitis B Surface Antibody, or Hepatitis B Core Antibody results
    - **Lab results within last 60 days:** ESR/CRP results
    - **Most recent Rapid 3 (if available)**
- Please indicate name and direct phone number of a contact within your office that we can speak with to obtain any additional information:
  - Name: \_\_\_\_\_
  - Phone Number: \_\_\_\_\_

**Paperwork can be faxed or emailed to (843)-824-2327, [infusionemail@articularishealthcare.com](mailto:infusionemail@articularishealthcare.com)**

Infusion Coordinators Brenna, Carlye or Stephanie will assist you with any questions at (843)-572-8932

#### Low Country Rheumatology Infusion Locations

Please mark preferred location and we will do our best to accommodate, however we cannot make any guarantees.

#### **Summerville**

2001 2nd Ave, Suite 201, Summerville, SC 29486

#### **Mount Pleasant**

1165 Chuck Dawley Blvd, Mt. Pleasant, SC 29464

#### **West Ashley**

2291 Henry Tecklenburg Drive, Charleston, SC 29414

Low Country Rheumatology Infusion Services will complete insurance verification and submit all required clinical documentation to the patient’s insurance company for eligibility. Our Infusion Coordinators will notify you if any further information is required. The patient will have an annual 30-minute consult with our NP to obtain H&P for chart. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

**Low Country Rheumatology Use Only** Existing Patient Yes \_\_\_\_\_ No \_\_\_\_\_ Physician \_\_\_\_\_

## Standard Orders for Inflectra (infliximab-dyyb) Administration

Patient \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**\*NOTE:** Patient is ineligible to receive Inflectra if they have suspected infectious process or is receiving antibiotic for active infectious process due to the possibility of developing a super infection related to its effect on the immune system.

**Indication:**

<input type="checkbox"/> K50.0 ____ Crohn's Disease (small intestine)	<input type="checkbox"/> K51.9 ____ Ulcerative Colitis, Unspecified	<input type="checkbox"/> K60.3 ____ Anal Fistula
<input type="checkbox"/> K50.1 ____ Crohn's Disease (large intestine)	<input type="checkbox"/> K51.5 ____ Left-sided Ulcerative (chronic) Colitis	<input type="checkbox"/> Other ICD-10 Code _____
<input type="checkbox"/> K50.8 ____ Crohn's Disease (small and large intestine)	<input type="checkbox"/> K51.8 ____ Other Ulcerative (chronic) Colitis	
<input type="checkbox"/> K63.2 ____ Fistula of intestine	<input type="checkbox"/> K51.0 ____ Universal Ulcerative (chronic) Pancolitis	

**History:**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Inadequate response to DMARDS</li> <li><input type="checkbox"/> Rapid 3 _____</li> <li><input type="checkbox"/> ESR/CRP _____</li> <li><input type="checkbox"/> HBsAg, HBsAb, HB core Ab, HCAb</li> <li><input type="checkbox"/> History of skin cancer</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Unable to tolerate DMARDS</li> <li><input type="checkbox"/> Swollen/tender joints</li> <li><input type="checkbox"/> Progressive erosive arthropathy</li> <li><input type="checkbox"/> Recent or upcoming surgical procedure</li> </ul> |
|--|--|

**Orders:**

- Standard Order Protocol:
  - Confirm current PPD, Tspot, or CXR
  - Confirm HbsAg, HBsAb, HB core Ab, HCAb negative
  - Obtain patient weight each visit
  - Evaluate patient for active infections, prior or upcoming surgical procedures, medication allergies, or any current health concerns as noted on Infusion Record
  - Baseline vitals will be obtained prior to administration, hourly during infusion and at the end of the infusion. Vital signs will be obtained more frequently if patient's condition warrants it.
  - Titrate infusion over 2 hours as recommended in Pfizer Infusion guide for doses 1-4, and for patients receiving pre-med due to previous infusion reaction. After dose 4, titrate infusion over 1 hour as tolerated.
  - **If infusion reaction occurs, slow or stop infusion, and initiate infusion reaction protocol per Articularis Healthcare Policy and Procedure Manual.**
  - Discharge instructions to include possible infusion side effects and follow-up appointment schedule

**Dose:**

- biosimilar infliximab-dyyb (Inflectra) \_\_\_\_\_ mg/kg in Normal Saline IV

**Frequency:**

- Initiation of Inflectra to be administered at week(s) 0, 2, and 6
- Maintenance dose every \_\_\_\_\_ weeks

**Premedicate:**

- No pre-med
- Pre-medicate x 1 dose 30 minutes prior to each infusion with:
  - 1000 mg Acetaminophen PO     25mg Benadryl PO/IV     125mg Solu-Medrol IV     Other \_\_\_\_\_

**Additional orders/comments:**

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Practice Name: \_\_\_\_\_

NPI: \_\_\_\_\_

Physician Name: \_\_\_\_\_

State License: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

DEA #: \_\_\_\_\_

Date: \_\_\_\_\_

UPIN: \_\_\_\_\_

