Updated September 17, 2019

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/*
- ☐ 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 (404 528-1852, argpriorauth@articularishealthcare.com

Arthritis & Rheumatology of GA
Prior Authorization Department will assist you with any questions at
(843)-572-8932 extension:910

Arthritis & Rheumatology of GA services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our Prior Authorization Department will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

Arthritis & Rheumatology of GA Use Only Existing Patient Yes____ No____ Physician _____

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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: *Please indicate the highest level of specificity.*

□ K50.0_____ Crohn's Disease (small intestine)		□ K51.9_____Ulcerative Colitis, Unspecified	□ K60.3____Anal Fistula
□ K50.1 _____Crohn's Disease (large intestine)		□ K51.5_____Left-sided Ulcerative (chronic) Colitis	□ Other ICD-10 Code _____
□ K50.8_____ Crohn's Disease (small and large intestine)		□ K51.8_____ Other Ulcerative (chronic) Colitis	
□ K63.2_____ Fistula of intestine		□ K51.0_____Universal Ulcerative (chronic) Pancolitis	

History:

□ Inadequate response to DMARDS

□ Rapid 3_____

□ ESR/CRP_____

□ HBsAg, HBsAb, HB core Ab, HCAb

□ History of skin cancer

□ Unable to tolerate DMARDS

□ Swollen/tender joints

□ Progressive erosive arthropathy

□ Recent or upcoming surgical procedure

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:

□ Inflectra (infliximab-dyyb) _____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:

_____

_____

Practice Name: _____

Physician Name: _____

Physician Signature: _____

Date: _____

NPI: _____

State License: _____

DEA #: _____

UPIN: _____

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