ChristianaCare™

DOCORD

DOCTOR'S ORDER SHEET
DEPARTMENT OF INFUSION SERVICES
INTRAVENOUS InFLIXimab AND BIOSIMILARS

Instructions:
1. Do not return charts with new or changed orders to rack.
2. Mark requested orders and/or boxes if indicated.

• Pre-marked box orders will be performed unless otherwise noted.
• No conditional (dependent on the approval of another physician) medication orders will be honored.

DOCTOR'S ORDER	REQUISITIONED	NOTED

This order form is not valid for prescribing of controlled substances

Instructions: Fax the below information

1. Completed and signed doctor's order sheet form (please include all pages)
2. Patient demographics including insurance information
3. Once all items are reviewed ChristianaCare Infusion Services will reach out to your patient to schedule

• **Phone:** 302-733-1548
• **Access coordinator:** 302-733-1553
• **Fax:** 302-733-1561

☐ New Referral
☐ Order Renewal
☐ Medication/Order Change

Date: _____ /_____ /_____
Patient name:
DOB: _____ /_____ /_____
Allergies:
Weight [kg or lb (mark one)]: _____ Date: ____ /____ /____
ICD 10:

☐ Insurance Authorization/Prior Auth number: _____

☐ If no insurance authorization needed provide confirmation/reference number: _____

1) **Pre-Medications:**
   A. ☐ Acetaminophen (e.g. Tylenol®) 650 mg PO once 30 minutes prior to infusion
   B. ☐ DiphenhydrAMINE (e.g. Benadryl®) 50 mg PO once 30 minutes prior to infusion
   C. ☐ Hydrocortisone (e.g. Solu-CORTEF®) _____ mg IV once 30 minutes prior to infusion
      OR
      ☐ MethylPREDNISolone (e.g. SOLU-Medrol®) _____ mg IV once 30 minutes prior to infusion
   D. ☐ Other (must include medication, dose, route and frequency): _____
      _____

2) **Indicate biosimilar to be dispensed:**
   ☐ InFLIXimab-axxq (Avsola®) ☐ InFLIXimab (Remicade®)
   ☐ InFLIXimab-abda (Renflexis®) ☐ InFLIXimab-dyyb (Inflectra®)

   ☐ Initial: 5 mg/kg IV on weeks 0, 2 and 6 then maintenance
   ☐ Maintenance: 5 mg/kg IV every _____ weeks

   OR

   ☐ Initial: _____ mg/kg IV on weeks 0, 2, and 6 then maintenance
   ☐ Maintenance: _____ mg/kg every _____ weeks

   ☐ Duration of order: _____ *orders will be honored for a max of 6 months*
   ☐ Other (must include medication, dose, route, frequency and duration): _____
   Note: Pharmacy to dose on actual body weight unless otherwise specified. Doses will be rounded to nearest vial size

_____ _____
Signature/Title Contact phone #

_____ _____/_____/_____ _____
Print Name or ID# Date Time

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Key:

BID	- Twice daily	MD	- Maintenance dose
D5W	- Dextrose 5% in water solution	mg	- Milligram
D/C	- Discontinue	min	- Minute
DOB	- Date of birth	mL	- Milliliter
HOH	- Hard of hearing	ng	- Nanogram
hr	- Hour	NPO	- Nothing by mouth
ICD	- International Classification of Diseases	NS	- 0.9% sodium chloride
IM	- Intramuscular	NSS	- Normal saline solution
IV	- Intravenous	PCA	- Patient controlled analgesia
kg	- Kilogram	PO	- By mouth
L	- Left	PRN	- As needed
LD	- Loading dose	R	- Right
LR	- Lactated ringers	TID	- Three times daily
mcg	- Microgram	X	- Times