INFLIXIMAB

(Including Remicade and biosimilars: Renflexis, Avsola, Inflectra)

FAX to + 1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Medication List • Tried/Failed Therapies • Negative TB Results

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.90 Crohn's disease, unspecified without complications
☐ K51.00 Ulcerative pancolitis (chronic) without complications
☐ K51.90 Ulcerative colitis, unspecified without complications
☐ L40.0 Psoriasis vulgaris
☐ L50.5 Arthropathic psoriasis, unspecified
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ Other: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol, there are no recommended standard pre-meds for Infliximab
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

·Remicade or biosimilar (Renflexis, Avsola, Inflectra) may be used according to payer guidelines
·To prohibit auto-substitution, please indicate specific brand required _____

☐ Infliximab 3mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab 5mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab 10mg/kg (mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab _____mg/kg (_____mg) IV every _____weeks
☐ Other: _____

*Initial calculated dose will become fixed dose throughout treatment. Check here to adjust dose per appointment ☐
*Dose will be rounded to nearest vial size (See infusionspecialist.org for rounding protocol). To prohibit dose rounding, check here ☐
*Patient will be eligible for 1hr infusions after 6 consecutive treatments without reaction. To prohibit rapid infusions, check here ☐

First Dose: ☐Y ☐N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ Provider Signature

_____ Date