

Infliximab (Remicade, Renflexis, Avsola)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Crohn's Disease: _____ Ulcerative Colitis: _____ Rheumatoid Arthritis: _____
Psoriatic Arthritis: _____ Ankylosing Spondylitis: _____ Other: _____

THERAPY ADMINISTRATION (Select one)

- Infuse infliximab (Remicade) OR infliximab biosimilar as required by patient's insurance.
 Infuse this infliximab product (subject to prior authorization)

DOSING (Select one)

- _____ mg IV
 _____ mg/kg x _____ kg IV = _____ mg
 Mix in 250ml of NS for doses less than 999mg. Mix in 500ml NS for doses greater than 1000mg.

FREQUENCY (Choose one)

- Week 0, 2, 6, and then every 8 weeks
 Every _____ weeks

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

- Tylenol 500mg / 650mg PO
 Loratadine 10mg PO
 Pepcid 20mg PO / IVP
 Benadryl 25mg / 50mg PO / IVP
 Solumedrol 40mg / 125mg IVP
 Other: _____

NURSING

- Hold infusion and notify provider for:
- Signs/symptoms of illness or active infection/cough, night sweats, or weight loss
 - Planned/recent surgical procedures or recent live vaccinations, TB, or Hep B positive.
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, biologic agent and steroids, colonoscopy or BSA of affected skin (by indication)

Required Labs: Include negative Hepatitis B within 3 years and Negative TB within 12 months.

Provider Name (print) _____

Provider Signature _____

Date _____

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.