## Infliximab (Remicade, Renflexis, Unbranded Infliximab)

**Provider Order Form rev.** 2/7/2025

PATIENT INFORMATION	Referral Statu	s: 🗆 New R	eferral 🛛 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 Da	ite:	Preferred Locatio	n:	
DIAGNOSIS (Please provide ICD-10 code in sp	ace provided)				
K50: Moderate to severe Crohn's disea	se 🛛 K51: N	Aoderate to se	vere ulcerative colitie	S	
L40: Psoriasis	□ M05:	Rheumatoid a	rthritis		
M06: Rheumatoid arthritis	□ M45:	Ankylosing spo	ondylitis		
□ Other:	Description:				
<ul> <li>Infuse infliximab (Remicade) OR infliximab biosin required by patient's insurance.</li> <li>Infuse this infliximab product (subject to prior and</li> </ul>			f 🛛 at each do	ose 🛛 every:	
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			
		<ul> <li>Hold infusion and notify provider for:         <ul> <li>Signs/symptoms of illness or active infection/cough, night sweats, or weight loss</li> <li>Planned/recent surgical procedures or recent live vaccinations, TB, or Hep B positive.</li> </ul> </li> </ul>			

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and postprocedure 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.