

# INFLIXIMAB

Date: \_\_\_\_\_

## Infusion orders

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

INFLIXIMAB IV BRANDS:	
<input type="checkbox"/> Remicade <input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Renflexis <input type="checkbox"/> Generic Infliximab	

<p><b>DIAGNOSIS</b> <i>Please provide ICD-10 code</i></p> <p><input type="checkbox"/> _____ Rheumatoid Arthritis</p> <p><input type="checkbox"/> _____ Psoriatic Arthritis 6 yro (PJIA)</p> <p><input type="checkbox"/> _____ Plaque Psoriasis</p> <p><input type="checkbox"/> _____ Ankylosing Spondylitis</p> <p><input type="checkbox"/> _____ Crohn's Disease</p> <p><input type="checkbox"/> _____ Ulcerative Colitis</p> <p><input type="checkbox"/> _____ (other)</p>	<p><b>PRE-MEDICATION</b></p> <p><input type="checkbox"/> Tylenol 1000mg PO <input type="checkbox"/> Solu-Medrol 125mg IVP</p> <p><input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Solu-Cortef 100mg IVP</p> <p><input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Diphenhydramine 25mg IVP</p> <p><input type="checkbox"/> _____ (other) <input type="checkbox"/> _____ (other)</p>
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<p><b>INFLIXIMAB ORDERS</b></p> <p><b>PATIENT WEIGHT</b></p> <p>_____ lbs.</p> <p>_____ kg</p> <p><b>DOSAGE:</b></p> <p><input type="checkbox"/> _____ mg/kg / IV <i>weight - based</i></p> <p><input type="checkbox"/> _____ mg <i>flat dosed</i></p> <p><b>Frequency:</b></p> <p><input type="checkbox"/> Every, 0,2,6, and every 8 weeks (<i>induction</i>)</p> <p><input type="checkbox"/> Every _____ weeks</p> <p><input type="checkbox"/> Quant _____</p> <p><input type="checkbox"/> Total dosage <input type="checkbox"/>/refills _____</p>
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<p><b>NOTES/ADDITIONAL COMMENTS:</b></p>    
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*If the medication selected above is not covered or is non-preferred by the patient's insurance, the prescribing provider authorizes consideration of the clinically appropriate alternatives listed below. Final medication selection will be based on provider clinical judgment and/or payer requirements. Provider signature below confirms authorization for the above substitution(s), if applicable.*

INFLIXIMAB IV BRANDS:  Remicade  Avsola  Inflectra  Renflexis  Generic Infliximab

**ORDERING PROVIDER**

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_