

Lexington  
1792 Alysheba Way  
Suite 205  
Lexington, KY 40509

Bowling Green  
727 U.S. 31 W Bypass  
Suite 102  
Bowling Green, KY 42101



# 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	

<b>DIAGNOSIS</b> <i>Please provide ICD-10 code</i> <input type="checkbox"/> _____ Rheumatoid Arthritis <input type="checkbox"/> _____ Psoriatic Arthritis 6 yro (PJIA) <input type="checkbox"/> _____ Plaque Psoriasis <input type="checkbox"/> _____ Ankylosing Spondylitis <input type="checkbox"/> _____ Crohn's Disease <input type="checkbox"/> _____ Ulcerative Colitis <input type="checkbox"/> _____ (other)	<b>PRE-MEDICATION</b> <input type="checkbox"/> Tylenol 1000mg PO <input type="checkbox"/> Solu-Medrol 125mg IVP <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Solu-Cortef 100mg IVP <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Diphenhydramine 25mg IVP <input type="checkbox"/> _____ (other) <input type="checkbox"/> _____ (other)
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<b>INFLIXIMAB ORDERS</b> <b>PATIENT WEIGHT</b> _____ lbs. _____ kg <b>DOSAGE:</b> <input type="checkbox"/> _____ mg/kg / IV <i>weight - based</i> <input type="checkbox"/> _____ mg <i>flat dosed</i> <b>Frequency:</b> <input type="checkbox"/> Every, 0,2,6, and every 8 weeks ( <i>induction</i> ) <input type="checkbox"/> Every _____ weeks <input type="checkbox"/> Quant _____ <input type="checkbox"/> Total dosage <input type="checkbox"/> /refills _____
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<b>NOTES/ADDITIONAL COMMENTS:</b>
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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 \_\_\_\_\_