Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

Office: 212-803-3339 Fax : 646-768-8600

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

INFLIXIMAB

Infusion orders

Date: ____________

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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:

☐ **Remicade** ☐ **Avsola** ☐ **Inflectra** ☐ **Renflexis** ☐ **Generic Infliximab**

DIAGNOSIS *Please provide ICD-10 code*

- ☐ ________ Rheumatoid Arthritis
- ☐ ________ Psoriatic Arthritis 6 yro (PJIA)
- ☐ ________ Plaque Psoriasis
- ☐ ________ Ankylosing Spondylitis
- ☐ ________ Crohn's Disease
- ☐ ________ Ulcerative Colitis
- ☐ ________ ______________________________ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ ______________________ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ ______________________ *(other)*

INFLIXIMAB ORDERS

PATIENT WEIGHT

___________ lbs.

___________ kg

DOSAGE:

- ☐ ___________ mg/kg / IV ***weight - based***
- ☐ ___________ mg ***flat dosed***

Frequency:

- ☐ Every, 0,2,6, and every 8 weeks ***(induction)***
- ☐ Every ________ weeks
- ☐ Quant________________
- ☐ Total dosage ☐/refills____________

NOTES/ADDITIONAL COMMENTS:

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 ______________