

Center City
1528 Walnut Street
Suite 1205
Philadelphia, PA 19102



King Of Prussia
216 Mall Blvd
Suite#1
King Of Prussia, PA, 19046

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	

DIAGNOSIS <small>Please provide ICD-10 code</small>	
<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)	

PRE-MEDICATION	
<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)

INFLIXIMAB ORDERS	
PATIENT WEIGHT	
_____ lbs.	
_____ kg	
DOSAGE:	
<input type="checkbox"/> _____ mg/kg / IV <i>weight - based</i>	
<input type="checkbox"/> _____ mg <i>flat dosed</i>	
Frequency:	
<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 _____	

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 _____