SPECIALTY INFUSION CENTERS

INFLIXIMAB ORDER FORM

☐ Avsola ☐ Remicade ☐ Inflectra ☐ Renflexis

*Biosimilar may need to be chosen based on payor guidelines

FAX TO: 800-540-1852

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F

Ht: _____ WT: _____ lbs / kg Primary Language: _____ Allergies: _____

Patient Preferred Location: ☐ Staten Island ☐ West Harrison ☐ Manhattan ☐ New Paltz ☐ Bronx ☐ Syosset ☐ Port Jefferson ☐ Millburn ☐ Brooklyn Heights ☐ Paramus

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

Gastroenterology

☐ K50. _____

☐ K51. _____

Dermatology

☐ L40. _____

Rheumatology

☐ M05. _____ ☐ M45. _____

☐ M06. _____ ☐ L40. _____ Other. _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
NOTE: Include Negative Hepatitis B within 3 years and Negative TB within 12 months.

PRESCRIPTION

Pre-Medications

☐ Tylenol 650mg PO
☐ Zyrtec 10mg PO
☐ Claritin 10mg PO
☐ Benadryl 25mg PO
☐ Benadryl 25mg IVP
☐ Benadryl 50mg PO
☐ Benadryl 50mg IVP
☐ Pepcid 20mg PO
☐ Pepcid 20mg IVP
☐ Solu-medrol 125mg IVP
☐ Solu-medrol 250mg IVP
☐ Solu-medrol 500mg IVP

Other: _____

Pre Labs:

☐ CBC ☐ Iron Panel
☐ CMP ☐ Vitamin D
☐ CRP ☐ Other _____
☐ ESR

Remicade (Infliximab)

Loading Dose: (for new infliximab patients)

☐ IV: Infuse _____ mg or _____ mg/kg at weeks 0, 2, and 6

Maintenance: (for all patients)

☐ IV: Infuse _____ mg or _____ mg/kg every _____ weeks for one year

In the event of an adverse reaction at a Specialty Infusion center, the adverse reaction protocol will be utilized.

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Supervising Provider (if applicable) _____

Date: _____ NPI#: _____ Specialty: _____

Practice Name: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____