alera care
advanced infusion centers™

FAX 833.329.4738

Infliximab (Remicade, Avsola, Inflectra, Renflexis)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): ____________________

Is the patient pregnant, planning a pregnancy or nursing: Yes No Does the patient need interpreter services: Yes No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

K50.90 Crohn's/Pediatric Crohn's Disease

K51.90 Ulcerative Colitis/Pediatric UC

M06.9 Rheumatoid arthritis

M45.9 Ankylosing Spondylitis

L40.50 Psoriatic Arthritis

L40.0 Plaque Psoriasis

Other: ____

Medication Order

Remicade (infliximab)	Preferred Agent (only select one)	Use if preferred agent is not covered by the patients insurance
Avsola (infliximab-axxq)	Preferred Agent (only select one)	Use if preferred agent is not covered by the patients insurance
Inflectra (infliximab-dyyb)	Preferred Agent (only select one)	Use if preferred agent is not covered by the patients insurance
Renflexis (infliximab-abda)	Preferred Agent (only select one)	Use if preferred agent is not covered by the patients insurance

Dose:

3mg/kg IV

5mg/kg IV

7.5mg/kg IV

10mg/kg IV

Other: _________________________

Round up to nearest 100mg from dosage indicated above

Give exact dose selected above

Frequency:

Initiation therapy: 0, 2 and 6 weeks then every 8 weeks

Initiation therapy: 0, 2 and 6 weeks then every 6 weeks

Initiation therapy: 0, 2 and 6 weeks then every _________weeks

Maintenance therapy: Every 8 weeks

Maintenance therapy: Every 6 weeks

Maintenance therapy: Every _________ weeks

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (Negative Hep B and TB) Insurance Card (front and back) Current Medications History/Progress Notes

Pre-Medication Orders

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg / PO IV

methylprednisolone (Solu-Medrol) 40mg IV 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: ____

Dose:__________________ Route:__________________ Frequency: __________________

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name

Provider Signature

Date

Order Expiration Date (mm/dd/yy): _________________ (If not indicated order will expire one year from date signature) Check here if this is a stat order