

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	L40.50 Psoriatic Arthritis
K51.90 Ulcerative Colitis/Pediatric UC	L40.0 Plaque Psoriasis
M06.9 Rheumatoid arthritis	Other: _____
M45.9 Ankylosing Spondylitis	

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:	Frequency:
3mg/kg IV	Initiation therapy: 0, 2 and 6 weeks then every 8 weeks
5mg/kg IV	Initiation therapy: 0, 2 and 6 weeks then every 6 weeks
7.5mg/kg IV	Initiation therapy: 0, 2 and 6 weeks then every _____ weeks
10mg/kg IV	Maintenance therapy: Every 8 weeks
Other: _____	Maintenance therapy: Every 6 weeks
Round up to nearest 100mg from dosage indicated above	Maintenance therapy: Every _____ weeks
Give exact dose selected above	

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
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Pre-Medication Orders

acetaminophen (Tylenol)	500mg	650mg	1000mg PO	diphenhydramine (Benadryl)	25mg	50mg /	PO	IV
cetirizine (Zyrtec)	10mg PO			methylprednisolone (Solu-Medrol)	40mg IV	125mg IV		
loratadine (Claritin)	10mg PO			hydrocortisone (Solu-Cortef)	100mg IV			
Other: _____								
Dose: _____			Route: _____			Frequency: _____		

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