

INFLIXIMAB

(Including Remicade and biosimilars: Renflexis, Avsola)



PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Medication List
- Tried/Failed Therapies
- Negative TB Results

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRIMARY DIAGNOSIS

- K50.00 Crohn's disease of small intestine without complications
- K50.10 Crohn's disease of large intestine without complications
- K50.90 Crohn's disease, unspecified without complications
- K51.00 Ulcerative (chronic) pancolitis without complications
- K51.90 Ulcerative colitis, unspecified without complications
- M06.9 Rheumatoid arthritis, unspecified
- Other: _____

PRE-MEDICATIONS

- Per infusion clinic protocol, there are no recommended standard pre-meds for Infliximab
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

*Remicade or biosimilar (Renflexis, Avsola) may be used according to payer guidelines
*To prohibit auto-substitution, please indicate specific brand required _____

- Infliximab 3 mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
- Infliximab 5 mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
- Infliximab 10 mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
- Infliximab _____mg/kg (_____mg) IV every _____ weeks
- Other: _____

*Initial calculated dose will become fixed dose throughout treatment. Check here to adjust dose per appointment
*Dose will be rounded to nearest vial size (See flexcareinfusion.com for rounding protocol). To prohibit dose rounding, check here

First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC
- Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals