

INFLIXIMAB ORDER FORM

Date: _____	ICD-10 Code: _____
Patient Name: _____	Allergies: _____
Date of Birth: _____	Weight: _____ lbs OR _____ kg
Therapy Status	Provider Information
<input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

Please specify desired agent: <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis <input type="checkbox"/> Avsola	<input type="checkbox"/> Initiation: Administer Infliximab _____ mg/kg IV over at least two hours at weeks 0, 2 and 6 per protocol. <input type="checkbox"/> Maintenance: Administer Infliximab _____ mg/kg IV at least two hours every _____ weeks per protocol.	Refills x one year from date of signature unless indicated below. <input type="checkbox"/> _____ Refills	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: ✓ Hepatitis B Surface Antigen. ✓ Hepatitis B Core Antibody. ✓ Negative TB Quantiferon Gold, TB Skin Test OR Chest X-Ray within the last 12 months.
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PRE-MEDICATIONS

Oral <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: _____ 10mg <input type="checkbox"/> Cetirizine: _____ 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	IV <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: _____ 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written: _____ _____ Prescriber Name	Substitution Allowed: _____ _____ Prescriber Name
_____ Date	_____ Date