TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

INFLIXIMAB ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

Please specify desired agent:

☐ Remicade

☐ Renflexis

☐ Avsola

☐ Initiation: Administer Infliximab_____ mg/kg IV over at least two hours at weeks 0, 2 and 6 per protocol.

☐ Maintenancee: Administer Infliximab_____ mg/kg IV at least two hours every_____ weeks per protocol.

Refills x one year from date of signature unless indicated below.

☐ _____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.
✓Hebatitis B Core Antibody.
✓Negative TB Quantiferon Gold, TB Skin Test OR Chest X-Ray within the last 12 months.

PRE-MEDICATIONS

Oral

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg
☐ Loratadine: ☐ 10mg
☐ Cetirizine: ☐ 10mg
☐ Diphenhydramine: ☐ 25mg ☐ 50mg
☐ Famotidine: ☐ 20mg ☐ 40mg
☐ Ibuprofen: ☐ 200mg ☐ 400mg ☐ 600mg
☐ Ondansetron: ☐ 4mg ☐ 8mg
☐ Other: _____

IV

☐ Dexamethasone: ☐ 4mg ☐ 8mg
☐ Diphenhydramine: ☐ 25mg ☐ 50mg
☐ Famotidine: ☐ 20mg ☐ 40mg
☐ Methylprednisolone: 125mg
☐ Hydrocortisone: ☐ 100mg
☐ Ondansetron: ☐ 4mg ☐ 8mg
☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date