TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

INFLIXIMAB ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Please specify desired agent:

☐ Remicade

☐ Renflexis

☐ Avsola

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

☐ Maintenance: Administer Infliximab _____ mg/kg IV over 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.

✓ Negative TB Quantiferon Gold, or TB Skin Test 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

(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