**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:*

Infliximab

Therapeutic Interchange to insurance preferred biosimilar authorized unless otherwise specified below:

_____

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

☐ Maintenance:
Administer _____ mg/kg IV over at least two hours every _____ weeks per protocol.

☐ If patient tolerates at least four infusions given over two hours, a shortened infusion rate of 1 hour may be utilized.

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:***

✓ Negative TB Quantiferon Gold or TB Skin Test within the last 12 months.

✓ Hepatitis B Surface Antigen

## 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:

Substitution Allowed:

V 12.27.23