

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



INFLIXIMAB ORDER FORM

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

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

<p>Please Specify Desired Agent: Infliximab</p> <p>Therapeutic Interchange to insurance preferred product authorized unless otherwise specified below:</p>	<input type="checkbox"/> Initiation: Administer _____ mg/kg IV over at least two hours at weeks 0, 2 and 6 per protocol. <input type="checkbox"/> Maintenance: Administer _____ mg/kg IV over at least two hours every _____ weeks per protocol. <input type="checkbox"/> If patient tolerates at least four infusions given over two hours, a shortened infusion rate of 1 hour may be utilized.	Refills for one year from date of signature unless indicated below. _____ Refills	<i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i> <input checked="" type="checkbox"/> Negative TB result and date: _____, Hepatitis B Surface Antigen.
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PRE-MEDICATIONS

<p>Oral</p> <p><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: _____</p>	<p>IV</p> <p><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: _____</p>
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<p>LAB ORDERS (please indicate any labs to be drawn and frequency)</p>	<p>(Please fax this signed order form, along with the following documents to 800-223-4063)</p> <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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Surveillance lab ordering and monitoring is the responsibility of the prescriber

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

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Prescriber Signature

Date