Infliximab (Remicade, Renflexis, Avsola)

Order Form
Rev. 2/20/2023

Infusion ASSOCIATES
Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ◉ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ◉ Yes *(please fax IA a copy)* ◉ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

TB Verification *(check one)*: ☐ TB Skin Test ☐ TB Spot/Quantiferon Blood Test ☐ Chest X-Ray

Result Date: _____ Result *(check one)*: ☐ Positive ☐ Negative

LAB ORDERS

Collect: ☐ BMP ☐ CMP ☐ CBC w/ Diff ☐ CBC w/o Diff ☐ CRP ☐ ESR ☐ Hepatic Panel ☐ _____

Lab Frequency: ◉ EVERY infusion ◉ Every OTHER infusion ◉ _____

PRE-MEDICATION ORDERS

◉ Diphenhydramine ◉ PO or ◉ IV ☐ 25mg or ☐ 50mg **OR** ◉ Cetirizine 10 mg PO

◉ Acetaminophen PO _____ mg

◉ Hydrocortisone IV Push _____ mg **OR** ◉ Methylprednisolone IV Push _____ mg

THERAPY ADMINISTRATION

Infliximab IV:

1) ◉ **IA provider to select product** (chosen based on patient's insurance coverage and availability).
2) ◉ **Select a product from the list below** (depending on the patient's health plan, choosing a specific drug may necessitate additional communication and the need for us to recommend an alternative infliximab).
   ☐ Renflexis ☐ Remicade ☐ Avsola ☐ Inflectra **not preferred*

Dose: ◉ 3 mg/kg ◉ 5 mg/kg ◉ 7.5 mg/kg ◉ 10 mg/kg ◉ _____ mg/kg ◉ _____ mg

Frequency: ☐ Initial Dose – 0, 2, 6 weeks, THEN ○ q6 weeks ○ q8 weeks ○ q _____ weeks

**If dosing ordered other than indicated by package insert, please provide a letter of medical necessity.*

When calculating dose, round to nearest: ◉ vial (100mg per vial) ◉ half vial (50mg increment)

Date of last infusion if not at IA: _____ RX Expiration Date: _____

_____ _____ _____

Provider Name (Print) **Provider Signature** **Date**