

INFLIXIMAB

(Including Remicade and biosimilars: Inflectra, Renflexis, Avsola)



PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Hep B Results

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRIMARY DIAGNOSIS

- K50.00 Crohn's disease of small intestine without complications
- K50.10 Crohn's disease of large intestine without complications
- K50.90 Crohn's disease, unspecified without complications
- K51.00 Ulcerative (chronic) pancolitis without complications
- K51.90 Ulcerative colitis, unspecified without complications
- M06.9 Rheumatoid arthritis, unspecified
- Other: _____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Infliximab

Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Infliximab 3 mg/kg IV at weeks 0,2,6, and every 8 weeks thereafter
- Infliximab 5 mg/kg IV at weeks 0,2,6, and every 8 weeks thereafter
- Infliximab 7.5 mg/kg IV at weeks 0,2,6, and every 8 weeks thereafter
- Infliximab 10 mg/kg IV at weeks 0,2,6, and every 8 weeks thereafter
- Infliximab _____ mg/kg IV every _____ weeks
- Other: _____

*Biosimilar (Remicade, Inflectra, Renflexis, Avsola) may be used according to payer guidelines, unless otherwise noted: _____

*Dose will be rounded up to nearest 100mg unless otherwise noted: _____

*Patient will be eligible for 1hr infusions after 6 consecutive treatments without reaction. To prohibit rapid infusions, check here

First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____