

INFLIXIMAB (AND BIOSIMILAR) ORDER FORM

- Infliximab (Remicade)
 Infliximab-axxq (Avsola)
 Infliximab-dyyb (Inflectra)
 Infliximab-qbtx (Ixifi)
 Infliximab-abda (Renflexis)
 OK to change to a suggested biosimilar above based on insurance or availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____
 Allergies: _____

DIAGNOSIS (Provider must specify)

- Rheumatoid Arthritis, ICD 10: M05.____ or M06.____
 Ankylosing Spondylitis, ICD 10: M45.____
 Plaque Psoriasis, ICD 10: L40.0
 Crohn's Disease, ICD 10: K50.____
 Psoriatic Arthritis, ICD 10: L40.____
 Ulcerative Colitis, ICD 10: K51.____
 Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics
 Labs and tests supporting diagnosis
 Office/progress notes

PRE-MEDICATION (Not typically indicated)

- Acetaminophen (Tylenol) 500 mg PO
 Famotidine 20 mg IV
 Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO
 Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Infliximab	<input type="checkbox"/> _____ mg/kg <input type="checkbox"/> _____ mg	<input type="checkbox"/> IV	<input type="checkbox"/> Weeks 0, 2, 6 and then every 8 weeks <input type="checkbox"/> Every 8 weeks <input type="checkbox"/> Every ____ weeks

New Start Therapy
 Continuation of Therapy
 Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: CT: 203.433.0621
 MD: 240.224.8607
 ME: 207.407.7272
 NH: 603.217.5371
 NJ: 201.581.4521
 VA: 703.202.0499

Order valid for 1 year from date of signature unless otherwise specified here: _____