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Ascend
INFUSION CENTERS

Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

INFLIXIMAB ORDER GI

☐ **New Start** ☐ **Maintenance: Last Dose Given____________**

Referring Office:	Contact Name:	Date
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies ☐ NKDA ☐ Allergies: ____

Height: ______________________ Weight: _______________

Indication:

☐ K50.0____ Crohn's Disease (small intestine)
☐ K50.1___ Crohn's Disease (large intestine)
☐ K50.8___ Crohn's Disease (small & large intestine)
☐ K51.0___ Universal Ulcerative (chronic) Pancolitis
☐ K51.5___ Left-sided Ulcerative (chronic) Pancolitis
☐ K51.8___ Other Ulcerative (chronic) Pancolitis
☐ K60.3___Anal Fistula
☐ K63.2___ Fistula of Intestine
☐ Other ____

DRUG: Avsola | Inflectra | Remicade | Renflexis | Unbranded Infliximab

☐ Infliximab-per insurance preferred
☐ Avsola (Infliximab-axxq)
☐ Inflectra (Infliximab-dyyb)
☐ Remicade (Infliximab)
☐ Renflexis (Infliximab-abda)
☐ Unbranded Infliximab

DOSE

☐ _____mg/Kg

FREQUENCY

☐ At weeks 0, 2, 6 then
☐ Every _______ weeks

PREMEDICATION ORDERS: *not required by PI*

☐ Acetaminophen po: ☐ 1000mg ☐500mg 30 min prior to infusion.
☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion.
☐ Solu-Medrol: ☐ 62.5mg IVP ☐ 100mg IVP ☐ Other______ 30 min prior to infusion.
☐ Other ____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

☐ Face Sheet / Patient Demographics
☐ Insurance card(s) – copy of front & back
☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)

Most Recent Labs (within last 4-8 weeks) – Required:

☐ CBC ☐ CMP ☐ TB ☐ Hep B Other: ____