

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 _____

<p>DRUG: Avsola Inflectra Remicade Renflexis Unbranded Infliximab</p> <p> <input type="checkbox"/> Infliximab-per insurance preferred <input type="checkbox"/> Avsola (Infliximab-axxq) <input type="checkbox"/> Inflectra (Infliximab-dyyb) <input type="checkbox"/> Remicade (Infliximab) <input type="checkbox"/> Renflexis (Infliximab-abda) <input type="checkbox"/> Unbranded Infliximab </p>	<p>DOSE</p> <p> <input type="checkbox"/> 5 mg/Kg IV <input type="checkbox"/> 10 mg/kg IV </p> <p>FREQUENCY</p> <p>At weeks 0, 2, 6 then every 8 weeks</p>
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PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion.
 Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.
 Methylprednisolone: 62.5mg IVP 125mg 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: _____