hŎűƶōŜǊ 2024

Ascend
INFUSION CENTERS

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

INFLIXIMAB ORDER RHEUMATOLOGY

☐ **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:

☐ M05.____ Rheumatoid Arthritis with Rheumatoid Factor
☐ K06.___ Rheumatoid Arthritis without Rheumatoid Factor
☐ M45.___Ankylosing Spondylitis
☐ D86.0___Sarcoidosis of the Lung
☐ L40.5___Psoriatic Arthropathy
☐ 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: ____