



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

L40.59 Psoriatic Arthropathy

Other

<p><b>DRUG:</b> Avsola   Inflectra   Remicade   Renflexis   Unbranded Infliximab</p> <p><input type="checkbox"/> Infliximab-per insurance preferred</p> <p><input type="checkbox"/> Avsola (Infliximab-axxq)</p> <p><input type="checkbox"/> Inflectra (Infliximab-dyyb)</p> <p><input type="checkbox"/> Remicade (Infliximab)</p> <p><input type="checkbox"/> Renflexis (Infliximab-abda)</p> <p><input type="checkbox"/> Unbranded Infliximab</p>	<p><b>DOSE</b></p> <p><input type="checkbox"/> 3mg/Kg IV</p> <p><input type="checkbox"/> 10mg/Kg IV every 4 weeks</p> <p><input type="checkbox"/> 10mg/Kg IV every 8 weeks</p> <p><b>FREQUENCY</b></p> <p><input type="checkbox"/> At weeks 0, 2, 6 then every 8 weeks</p> <p><input type="checkbox"/> 5mg/Kg IV: 0,2,6 then every 6 weeks-AS</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: \_\_\_\_\_