Local Infusion

MYLOCALINFUSION.COM

INFLIXIMAB (AND BIOSIMILAR) ORDER FORM

❑ Infliximab (Remicade) ❑ Infliximab-axxq (Avsola) ❑ Infliximab-dyyb (Inflectra) ❑ Infliximab-abda (Renflexis)

❑ **Dispense As Written (DAW)**

Will substitute for biosimilar or reference product based on insurance and availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

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

DIAGNOSIS (Provider must specify)

❑ Rheumatoid Arthritis, ICD 10: M05._____ or M06._____

❑ Plaque Psoriasis, ICD 10: L40.0

❑ Psoriatic Arthritis, ICD 10: L40._____

❑ Other:_____

❑ Ankylosing Spondylitis, ICD 10: M45._____

❑ Crohn's Disease, ICD 10: K50._____

❑ Ulcerative Colitis, ICD 10: K51._____

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

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ Methylprednisolone (Solu-Medrol) 125mg IVP

☑ Benadryl 25mg PO

❑ Famotidine 20mg IV

☑ Acetaminophen (Tylenol) 500mg PO

❑ Cetirizine (Zyrtec) 10mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Infliximab	❑ _____mg/kg ❑ _____mg	IV	❑ Weeks 0, 2, 6 and then every 8 weeks ❑ Weeks 0, 2, 6 and then every _____ weeks ❑ Every 8 weeks ❑ Every _____ weeks

LABS / SPECIAL INSTRUCTIONS