# INFLIXIMAB

(Including Remicade and biosimilars: Inflectra, Renflexis, Avsola)

FLEXCARE INFUSION CENTERS

## PATIENT DEMOGRAPHICS

| | |
|---|---|
| Patient Name: | Patient's Phone Number: |
| Date of Birth: | Address: |
| Allergies: See List ☐ NKDA ☐ | City, State, Zip: |
| Weight:_____lbs or _____kg | Patient's Email: |

## REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Hep B Results

## LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

## PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified without complications
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.90 Ulcerative colitis, unspecified without complications
☐ M06.9 Rheumatoid arthritis, unspecified
☐ Other: _____

## PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Infliximab

☐ Provider Prescribed: _____

_____

## PRIMARY MEDICATION ORDER

☐ Infliximab 5 mg/kg IV at weeks 0,2,6, and every 8 weeks thereafter
☐ Infliximab 10 mg/kg IV at weeks 0,2,6, and every 8 weeks thereafter
☐ Infliximab _____mg/kg IV every_____weeks
☐ Other: _____

*Biosimilar (Remicade, Inflectra, Renflexis, Avsola) may be used according to payer guidelines, unless otherwise noted: _____

*Dose will be rounded up to nearest 100mg unless otherwise noted: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

## LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol
(See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

## PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

| | |
|---|---|
| Provider Name: | Office Contact: |
| Address: | Phone: |
| City, State, Zip: | ☐ Fax: |
| NPI **AND** License: | ☐ Email: |

Provider Signature _____ Date _____

**FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals**