PREMIER VITALITY
Physician-led · Patient-centered · Infusion-care

Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

INFLIXIMAB ORDER DERMATOLOGY ☐ **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:
☐ L40.5____ Psoriatic Arthritis/Arthropathy
☐ L40._____Psoriasis
☐ Other _____

DRUG: Avsola | Inflectra | Remicade | Renflexis | Unbranded Infliximab ☐ Infliximab-per insurance preferred	**DOSE**
☐ Avsola (Infliximab-axxq)	☐ _____mg/Kg
☐ Inflectra (Infliximab-dyyb)	**FREQUENCY**
☐ Remicade (Infliximab)	☐ At weeks 0, 2, 6 then
☐ Renflexis (Infliximab-abda)	☐ Every _____ weeks
☐ Unbranded Infliximab	

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 <u>ALL</u> 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: _____