PREMIER VITALITY

Physician-led · Patient-centered · Infusion-care

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

INFLIXIMAB ORDER GI

☐ **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:

☐ K50.0____ Crohn's Disease (small intestine) ☐ K50.1___ Crohn's Disease (large intestine) ☐ K50.8___ Crohn's Disease (small & large intestine) ☐ K51.0___ Universal Ulcerative (chronic) Pancolitis ☐ K51.5___ Left-sided Ulcerative (chronic) Pancolitis ☐ K51.8___ Other Ulcerative (chronic) Pancolitis ☐ K60.3___Anal Fistula ☐ K63.2___ Fistula of Intestine

☐ 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 <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: _____