immersiv HEALTH

INFLIXIMAB ORDER FORM

REMICADE® OR BIOSIMILAR (AVSOLA®, INFLECTRA®, RENFLEXIS®) MAY BE USED ACCORDING TO PAYOR GUIDELINES

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

***PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

- ☐ K50.00 Crohn's Disease – small intestine
- ☐ K50.10 Crohn's Disease – large intestine
- ☐ K50.80 Crohn's Disease – small & large intestine
- ☐ K50.90 Crohn's Disease, unspecified
- ☐ K51.00 Universal Ulcerative Pancolitis – chronic
- ☐ K51.50 Left sided Ulcerative Colitis – chronic
- ☐ K51.80 Other Ulcerative Colitis – chronic
- ☐ K51.90 Ulcerative Colitis
- ☐ L40.0 Psoriasis vulgaris
- ☐ L40.5 Psoriatic Arthropathy
- ☐ M05.___ Rheumatoid arthritis w/ rheumatoid factor
- ☐ M06.___ Rheumatoid arthritis w/o rheumatoid factor
- ☐ M45.9 Ankylosing Spondylitis

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & failed Therapies ☐ Most recent History & Physical ☐ Negative TB Screening ☐ Hep-B Screening

MEDICATION ORDER

Remicade® or biosimilar (Avsola®, Inflectra®, Renflexis®) may be used according to payor guidelines

To restrict substitution, indicate required brand here: _____

Induction

- ☐ Infliximab 3 mg/kg IV per protocol at week 0, week 2, and week 6
- ☐ Infliximab 5 mg/kg IV per protocol at week 0, week 2, and week 6
- ☐ Infliximab _____ mg/kg or _____ mg IV per protocol at week 0, week 2, and week 6

Maintenance

- ☐ Infliximab 3 mg/kg IV per protocol every 8 weeks
- ☐ Infliximab 5 mg/kg IV per protocol every 8 weeks
- ☐ Infliximab _____ mg/kg or _____ mg IV per protocol every 8 weeks

*Maintenance dosing scheduled 8 weeks from last induction dose (week 6 dose)

☐ **OTHER:** _____

PRE-MEDICATIONS

PO

- ☐ Acetaminophen: 650 mg
- ☐ Cetirizine: 10 mg
- ☐ Diphenhydramine: 25 mg

IV

- ☐ Methylprednisolone: 125 mg
- ☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

LAB ORDERS

LAB: _____ FREQUENCY: _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first infusion.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: (IF APPLICABLE) _____ **CONTACT NAME:** _____

SIGNATURE: (NO STAMPS) _____ _____ **DATE:** _____

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN