

## 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

- |   |  |
|---|--|
| <input type="checkbox"/> K50.00 Crohn's Disease - small intestine         | <input type="checkbox"/> K51.90 Ulcerative Colitis                             |
| <input type="checkbox"/> K50.10 Crohn's Disease - large intestine         | <input type="checkbox"/> L40.0 Psoriasis vulgaris                              |
| <input type="checkbox"/> K50.80 Crohn's Disease - small & large intestine | <input type="checkbox"/> L40.5 Psoriatic Arthropathy                           |
| <input type="checkbox"/> K50.90 Crohn's Disease, unspecified              | <input type="checkbox"/> M05. _____ Rheumatoid arthritis w/ rheumatoid factor  |
| <input type="checkbox"/> K51.00 Universal Ulcerative Pancolitis - chronic | <input type="checkbox"/> M06. _____ Rheumatoid arthritis w/o rheumatoid factor |
| <input type="checkbox"/> K51.50 Left sided Ulcerative Colitis - chronic   | <input type="checkbox"/> M45.9 Ankylosing Spondylitis                          |
| <input type="checkbox"/> K51.80 Other Ulcerative Colitis - chronic        |  |
| <input type="checkbox"/> 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: \_\_\_\_\_

### 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.

## PRE-MEDICATIONS

### PO

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

### IV

- Methylprednisolone: 125 mg  
 Diphenhydramine: 25 mg

OTHER: \_\_\_\_\_  PO  IV

## PRESCRIBER INFORMATION

PROVIDER NAME: \_\_\_\_\_ NPI #: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS (INCLUDE CITY, STATE, ZIP): \_\_\_\_\_

SUPERVISING PHYSICIAN: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_  
(IF APPLICABLE)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN