

INFLIXIMAB

(Including Remicade and biosimilars: Renflexis, Avsola)

Fax to 888-360-2455

Email: Referrals@curbsideinfusion.com

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Medication List
- Tried/Failed Therapies
- Negative TB Results

LABS: PLEASE INCLUDE FREQUENCY

Labs patient should be reminded to have drawn _____

PRIMARY DIAGNOSIS

- | | |
|--|---|
| <input type="checkbox"/> K50.00 Crohn's disease of small intestine without complications | <input type="checkbox"/> K51.90 Ulcerative colitis, unspecified without complications |
| <input type="checkbox"/> K50.10 Crohn's disease of large intestine without complications | <input type="checkbox"/> M06.9 Rheumatoid arthritis, unspecified |
| <input type="checkbox"/> K50.90 Crohn's disease, unspecified without complications | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> K51.00 Ulcerative (chronic) pancolitis without complications | |

PRE-MEDICATIONS

- Per infusion clinic protocol, there are no recommended standard pre-meds for Infliximab
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

*Remicade or biosimilar (Renflexis, Avsola) may be used according to payer guidelines

*To prohibit auto-substitution, please indicate specific brand required _____

- Infliximab 3 mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
- Infliximab 5 mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
- Infliximab 10 mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
- Infliximab _____mg/kg (_____mg) IV every _____ weeks
- Other: _____

• First Dose: Y N

Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per Curbside Infusion Ventures' protocol
- Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion reaction and anaphylaxis medications per Curbside Infusion Venture protocol
- 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:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____