EXPECARE FAMILY CARE | URGENT CARE OF TEXAS

Infliximab Order Form
(infliximab)

FAX TO: 817-472-7213

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

DERMATOLOGY
- ☐ L40.5_____ Psoriatic Arthritis/Arthropathy
- ☐ L40._____ Psoriasis

GASTROENTEROLOGY
- ☐ K50.0_____ Crohn's Disease, Small Intestine
- ☐ K50.1_____ Crohn's Disease, Large Intestine
- ☐ K50.8_____ Crohn's Disease, Small & Large Intestine
- ☐ K50.9_____ Crohn's Disease, Unspecified
- ☐ K51.8_____ Other Ulcerative Colitis, Chronic
- ☐ K51.5_____ Left Sided - Ulcerative Colitis, Chronic
- ☐ K51.0_____ Universal Ulcerative Pancolitis, Chronic
- ☐ K51.9_____ Ulcerative Colitis, Unspecified
- ☐ K60.3 Anal Fistula
- ☐ K63.2 Fistula of Intestine

RHEUMATOLOGY
- ☐ M05._____ Rheumatoid Arthritis, w/ Rheumatoid Factor
- ☐ M06._____ Rheumatoid Arthritis, w/o Rheumatoid Factor
- ☐ L40.5_____ Psoriatic Arthritis/ Arthropathy
- ☐ M45._____ Ankylosing Spondylitis
- ☐ D86.0 Sarcoidosis of the Lung

OTHER:_____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
LAB RESULTS: Include Negative Hepatitis B within 3 years and Negative TB within 12 months.

PRESCRIPTION

Pre-Medications
- ☐ Acetaminophen: 650 mg PO
- ☐ Cetirizine: 10 mg PO
- ☐ Diphenhydramine: 25 mg PO
- ☐ Diphenhydramine: 25 mg IVP
- ☐ Famotidine: 20 mg PO
- ☐ Methylprednisolone: 125 mg SIVP
- ☐ Other: _____

Lab Orders+
Required: Negative TB, annually

+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose:
_____

Drug

☐ Remicade (Infliximab) **OR** Biosimilar as dictated by patient's insurance*

* ***Medix Infusion will determine appropriate product based upon benefit investigation***

OR

☐ Infliximab product _____ (DO NOT SUBSTITUTE)

Infuse in 250 mL of 0.9% NS over at least 2 hours via pump with 0.2-micron filter. Doses>1000 mg need total volume of 500 mL. Medix Infusion offers Infliximab at a reduced infusion time, beginning on the 4th and subsequent infusions, to patients who qualify and consent

Loading Dose (SELECT ONE)
- ☐ **IV:** Infuse 3 mg/kg at weeks 0, 2, and 6
- ☐ **IV:** Infuse 5 mg/kg at weeks 0, 2, and 6
- ☐ **IV:** Infuse _____ mg **or** _____ mg/kg at weeks 0, 2, and 6

Maintenance Dose (SELECT ONE)
- ☐ **IV:** Infuse 3 mg/kg every 8 weeks for one year
- ☐ **IV:** Infuse 5 mg/kg every 8 weeks for one year
- ☐ **IV:** Infuse _____ mg **or** _____ mg/kg every _____ weeks for one year

MEDIX USE ONLY
Product to be used:
- ☐ Remicade
- ☐ Avosla
- ☐ Inflectra
- ☐ Renflexis

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____