

Infliximab-abda (Renflexis)

REFERRAL STATUS: New Referral Dose or Frequency Change Order Renewal
Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:	DOB:	
<input type="checkbox"/> NKDA Allergies:	Weight (lbs / kg):	Height:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy - Last Treatment Date:		Next Due Date:	
PROVIDER INFORMATION			
Office Contact Name:		Office Email:	
Prescribing Providers Name:		Provider NPI:	
Office Address:		City:	State: Zip:
Office Phone Number:		Office Fax Number:	
DIAGNOSIS AND ICD 10 CODE			
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis		ICD 10 Code: K51.90	
<input type="checkbox"/> Moderate to Severe Crohn's Disease		ICD 10 Code: K50.90	
<input type="checkbox"/> Rheumatoid Arthritis		ICD 10 Code: M06.9	
<input type="checkbox"/> Ankylosing Spondylitis		ICD 10 Code: M45.9	
<input type="checkbox"/> Psoriatic Arthritis		ICD 10 Code: L40.52	
<input type="checkbox"/> Plaque Psoriasis		ICD 10 Code: L40.0	
<input type="checkbox"/> Other: _____		ICD10 Code: _____	
REQUIRED DOCUMENTATION/Testing			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance info <input type="checkbox"/> Clinical/Progress notes supporting primary dx <input type="checkbox"/> Labs and Tests supporting primary diagnosis		<input type="checkbox"/> Hepatitis B Test Results: HBsAg, Total HepB Core Total Antibody <input type="checkbox"/> TB Test Results	
List Tried & Failed Therapies 1)		2)	
PREMEDICATION ORDERS			
<input type="checkbox"/> acetaminophen (Tylenol) PO <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg <input type="checkbox"/> diphenhydramine (Benadryl) PO / IV <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg (if route is not circled PO will be administered) <input type="checkbox"/> methylprednisolone (Solu-Medrol) IV <input type="checkbox"/> 60mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg <input type="checkbox"/> ____ mg <input type="checkbox"/> Other:			
MEDICATION ORDERS			
Please check box <input type="checkbox"/> if ok to substitute with an infliximab biosimilar per insurance preferred product			
Dose	<input type="checkbox"/> 3mg/kg <input type="checkbox"/> 5mg/kg <input type="checkbox"/> 7.5mg/kg <input type="checkbox"/> 10mg/kg <input type="checkbox"/> _____ <input type="checkbox"/> Round up to nearest 100mg		
Frequency	<input type="checkbox"/> Induction: at weeks 0, 2, 6 then every 8 weeks thereafter <input type="checkbox"/> Maintenance: every 8 weeks <input type="checkbox"/> Other: _____ every _____ weeks		
Refills*: <input type="checkbox"/> None <input type="checkbox"/> X6 months <input type="checkbox"/> X1 year <input type="checkbox"/> Other: _____ <i>*(if not indicated order will expire one year from date signed)</i>			

****Please check box if ok to substitute for an Infliximab biosimilar insurance preferred product.**

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Provider Name (Print)

Physician Signature:

Date:

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Created 1/27/23