

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"/> Hepatitis B Test Results: HBsAg, Total HepB Core Total Antibody
<input type="checkbox"/> Patient demographics AND insurance info	<input type="checkbox"/> TB Test Results
<input type="checkbox"/> Clinical/Progress notes supporting primary dx	
<input type="checkbox"/> Labs and Tests supporting primary diagnosis	

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 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*: None X6 months X1 year Other: _____

**(if not indicated order will expire one year from date signed)*

Provider Name (Print) _____ **Physician Signature:** _____ **Date:** _____

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.