MIC | METRO INFUSION CENTER

Infliximab/Biosimilar (Any infliximab product as required by the patients health plan*)

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ 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			
☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90		
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90		
☐ Rheumatoid Arthritis	ICD 10 Code: M06.9		
☐ Ankylosing Spondylitis	ICD 10 Code: M45.9		
☐ Psoriatic Arthritis	ICD 10 Code: L40.52		
☐ Plaque Psoriasis	ICD 10 Code: L40.0		
☐ Other: _____	ICD10 Code: _____		
REQUIRED DOCUMENTATION/Testing			
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx ☐ Labs and Tests supporting primary diagnosis	☐ Hepatitis B Test Results: HBsAg, Total HepB Core Total Antibody ☐ TB Test Results		
List Tried & Failed Therapies 1)	2)		
PREMEDICATION ORDERS			
☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg ☐ diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered) ☐ methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ _____ mg ☐ Other:			
MEDICATION ORDERS			
☒ **Provider will select product (chosen based on patient's insurance coverage and availability)**			
Dose IV	☐ 3 mg/kg ☐ 5 mg/kg ☐ 7.5 mg/kg ☐ 10 mg/kg ☐ _____ mg/kg ☐ _____ mg		
Frequency	☐ Induction: at weeks 0, 2, 6 **THEN** ☐ q6 weeks ☐ q8 weeks ☐ q _____ weeks *if outside of **PI** please provide a letter of medical necessity		
*Infliximab products include: Remicade, Unbranded Infliximab, Avsola, Inflectra, Renflexis			

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.

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