

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____
Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

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

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)

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

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: _____