medix infusion

Remicade® Order Form
(infliximab)

FAX TO: 972.499.9210

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

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 & 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
Avsola
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.

Comments:

____

Prescriber Information

Prescriber Name: ______________________________________ Signature: ______________________________

Date: ______________ NPI #: __________________________ Specialty: ______________________________

Supervising Physician: ____ (If Applicable)

Address: _____________________________ City: ____________________________ State: __________ Zip: __________

Contact Name: ____________________ Phone: ______________ Fax: ______________ Email: ______________________