Infliximab® Order Form
(infliximab)

medix infusion

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

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
- ☐ Other ICD 10 Code: _____ Description _____

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:_____

Medication Order

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+

Requested Add'l Lab Orders:

_____

_____

_____

Drug

☐ Remicade (Infliximab) **OR** Biosimilar as dictated by patient's insurance*

* ***Medix Infusion will determine appropriate product based upon benefit investigation***

Loading Dose (SELECT ONE)
- ☐ **IV:** Infuse 3 mg/kg at weeks 0, 2, and 6 then every 8 weeks x 1 year
- ☐ **IV:** Infuse 5 mg/kg at weeks 0, 2, and 6 then every 8 weeks x 1 year
- ☐ **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

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

ACCELERATED INFUSION: After 4 consecutive lifetime doses without adverse reactions, administration time may be reduced to the protocol:
Decline accelerated rate. Yes ☐ No ☐

Comments: _____

Required Clinical Documentation

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. Medix Infusion will collect all necessary labs if not included in referral documents.

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

_____

Referring Provider Information

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

© Medix Infusion 2026