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

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. 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:

_____

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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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