INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Infliximab *Remicade & biosimilars*

- ☐ Infliximab (Remicade)
- ☐ Infliximab-axxq (Avsola)
- ☐ Infliximab-dyyb (Inflectra)
- ☐ Infliximab-abda (Renflexis)
- ☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

- ☐ Rheumatoid Arthritis, ICD 10: M05. or M06.
- ☐ Ankylosing Spondylitis, ICD 10: M45.
- ☐ Plaque Psoriasis, ICD 10: L40.0
- ☐ Crohn's Disease, ICD 10: K50.
- ☐ Psoriatic Arthritis, ICD 10: L40.
- ☐ Ulcerative Colitis, ICD 10: K51.
- ☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

- ☐ Negative TB
- ☐ Demographics
- ☐ Office/progress notes
- ☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
- ☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

- ☑ Acetaminophen (Tylenol) 500 mg PO
- ☐ Famotidine 20 mg IV
- ☑ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ☑ Diphenhydramine (Benadryl) 25 mg PO
- ☐ Cetirizine (Zyrtec) 10 mg PO
- ☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Infliximab	☐ _____ mg/kg ☐ _____ mg	IV	☐ Weeks 0, 2, 6 and then every 8 weeks ☐ Every 8 weeks ☐ Every _____ weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____