INFLIXIMAB (AND BIOSIMILAR) ORDER FORM

☐ **Infliximab (Remicade)** ☐ **Infliximab-axxq (Avsola)** ☐ **Infliximab-dyyb (Inflectra)** ☐ **Infliximab-qbtx (Ixifi)**
☐ **Infliximab-abda (Renflexis)** ☐ **Dispense As Written (DAW)**
Will substitute for biosimilar or reference product based on insurance and availability

Patient Name:		DOB:
Mobile Number	Patient Weight: kg	Patient height: In
Allergies		

PROVIDER INFORMATION

Provider Name		Provider NPI:
Signature:		Date:
Contact Name:	Phone:	Fax:

Prerequisites to treatment — ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

DIAGNOSIS (Provider must specify)

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

PRE-MEDICATION

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Cetirizine 10 mg PO

☐ Methylprednisolone (Soil-I-Medrol) 125mg IV ☐ Benadryl 25mg PO

Other: Dose: Route:

Medication

Medication	Dose	Route	Frequency	Duration
Infliximab	☐ _____mg/kg ☐ ❑ ____mg	IV	☐ Every 0,2,6 then 8 weeks ☐ Every 8 weeks ☐ Every weeks	☐ 1 Year ☐ Or Refills:

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable):

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified
Please fax your order to one of the following locations.

One Care Infusion Pharmacy
2025 Chicago Ave, STE A3
Riverside, CA 92507
Ph: 951-900-1120
Fax: 951-900-1125

One Care Infusion Pharmacy
907 W Coal Ave
Gallup, NM 87301
Ph: 505-726-4155
Fax: 505-726-4304