

Infliximab Referral Form



REQUIRED INFORMATION

- ☐ This signed order form from the provider
- ☐ Patient demographics and insurance information
- ☐ Clinical/Progress Notes, Labs (including TB Gold and Hep B surface antigen and Hep B Core AB total required), and Tests supporting primary diagnosis (ICD-10 below)
- ☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	
Diagnosis: ☐ Rheumatoid Arthritis (ICD-10 _____) ☐ Crohn's Disease (ICD-10 _____) ☐ Ankylosing Spondylitis (ICD-10 _____) ☐ Ulcerative Colitis (ICD-10 _____) ☐ Psoriasis (ICD-10 _____) ☐ Other (ICD-10 _____)		
☐ Infuse infliximab OR infliximab biosimilar as required by patient's insurance (Remicade, Avsola, Inflectra, Renflexis) ☐ Do not substitute. Infuse the following brand: _____ Infliximab Dose: _____ ☐ mg/kg IV To be infused over 2 hours; may shorten infusion time to 1 hour in patients tolerating at least four 2-hour infusions Frequency: ☐ 0, 2, 6 then every 8 weeks OR every _____ week(s) Refill: ☐ PRN x 1 year OR _____ times Protocol Pre-Medication Orders: ☐ Acetaminophen 650 mg PO OR ☐ Acetaminophen 1000 mg PO ☐ Diphenhydramine 25 mg PO OR ☐ Cetirizine 10 mg PO Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IV ☐ Other: _____		
Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician Labs: _____ Frequency: _____ TB, Hepatitis B, CBC, and LFTs should be followed at regular intervals		
Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed ☐ May use Burnham's Vital Care flush and catheter maintenance protocol		
Nursing Orders: ☐ Pharmacy to provide nursing services, including vascular access, administration, and line care ☐ May use Burnham's Vital Care anaphylaxis protocol		
Additional Instructions: 		
Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		

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