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 _____)
☐ Ankylosing Spondylitis (ICD-10 _____)
☐ Psoriasis (ICD-10 _____)
☐ Crohn's Disease (ICD-10 _____)
☐ Ulcerative Colitis (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: