Infliximab Biosimilars

Provider Order Form Rev. 08/2024

Please fax completed referral form & all required documents to (833) 786-0025

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: _______ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

**ICD 10 Code Required*

☐ Crohn's Disease (K50.00-K50.919), ICD10 ___________

☐ Ulcerative Colitis (K51.00-K51.919), ICD10 ___________

☐ Rheumatoid Arthritis (M05.70-M05.9, M06.00-M06.09, M06.9), ICD10 ___________

☐ Psoriatic Arthritis (L40.50.-L40.59), ICD10 ___________

☐ Plaque Psoriasis (L40.0-L40.4, L40.8-L40.9), ICD10 ___________

☐ Ankylosing Spondylitis (M45.0-M45.9), ICD10 ___________

☐ Other: ______________________, ICD10 ___________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Infliximab biosimilars available: ☐ Avsola® (infliximab-axxq) ☐ Inflectra® (infliximab-dyyb) ☐ Remicade® (infliximab) ☐ Renflexis® (infliximab-abda)	☐ ________ mg (3 mg/kg) ☐ ________ mg (5 mg/kg) ☐ ________ mg (10 mg/kg) ☐ ________ mg (____ mg/kg)	☐ **INITIAL:** Infuse IV over 2 hours at Weeks 0, 2, 6, then every ______ weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 2 hours every ______ weeks x 1 year Shortened Infusion (only if patient tolerated at least 4 infusions given over 2 hours): ☐ **MAINTENANCE:** Infuse IV over 1 hour every ______ weeks x 1 year

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: ______________________

Date of last treatment: ______________ Date of next treatment: ______________

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: ______________________

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _________ ☐ CMP q _________ ☐ CRP q _________

☐ ESR q _________ ☐ LFTs q _________ ☐ Other: _________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________

Physician Name: ______________________ NPI: ____________ TIN: ____________ Specialty: ____________

Address: ______________________ City/ST/Zip: ______________________

Contact Person: ______________________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

- Provide copy of TB screening (within 12 months) and must be completed annually by: ☐ Infusion Center ☐ Referring Physician
- Provide copy of Hepatitis B Screening
- Provide copy of baseline CBC, CMP and LFT

PRIOR FAILED THERAPIES

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________