Remicade

(Or other Infliximab products such as Inflectra, Avsola, or Renflexis as required by the patient's health plan.)

Treatment Location: Dublin, OH Lancaster, OH

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, Recent TB & Hep B Results

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal ☐ Home Infusion

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ K50.____ ☐ K51.____ ☐ M06.00 ☐ M05.60 ☐ M05.70 ☐ M45.9 ☐ L40.50 ☐ L40.0 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infuse One Ohio

☑ TB Results (list results/date & attach clinicals):

____

☑ Hepatitis B Status & Date (list results & attach clinicals):

____

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: ______________________________

Dose: __________ Route: _________ Frequency: ____________

THERAPY ADMINISTRATION

☑ Infliximab Intravenous Infusion

Dose:

Weight Based: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg

OR ☐ Total dose = ______ mg

☐ Other: ______________________________

☐ Round UP to the nearest 100mg vial OR ☐ Give exact dose

☐ Rapid infusion (over one hour) starting after first maintenance infusion

Frequency:

☐ Induction: Week 0, 2, and 6

☐ Maintenance: Every ☐ 4 weeks / ☐ 6 weeks / ☐ 8 weeks

☐ Other: ______________________________

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ________________
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print) ______________ Provider Signature ______________ Date ______________

☐ ***Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***