INTRAMED Plus
infusion services

INFLIXIMAB

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis:
_____Rheumatoid Arthritis ICD-10 Code: _____
_____Crohn's Disease ICD-10 Code: K50. _____
_____Ulcerative Colitis ICD-10 Code: K51. _____
_____Ankylosing Spondylitis ICD-10 Code: M45. _____
_____Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- TB Screening Results
- Hepatitis Screening Results

Patient
Weight: _____ lbs.
Height: _____ in.

Infliximab

4. Drug Order (select one):

❑ **Remicade** (J1745) Dose: _____ or _____ mg/kg every _____ weeks or ❑ 0, 2, 6 then every 8 weeks

❑ **Inflectra** (Q5103) Dose: _____ or _____ mg/kg every _____ weeks or ❑ 0, 2, 6 then every 8 weeks

❑ **Avsola** (Q5121) Dose: _____ or _____ mg/kg every _____ weeks or ❑ 0, 2, 6 then every 8 weeks

Administer IV over 2 hours for a total of six months

Pre-Medication Orders: Acetaminophen 650 mg PO
Administered 30 min prior to infusion *Adjust to patient's needs

❑ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 800.767.6337