

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

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| Patient Weight: _____ lbs. Height: _____ in. |
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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 #: _____

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| FAX ALL INFORMATION CENTRAL FAX 803.999.1754 | INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760 |
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