

Infliximab (Remicade, Avsola, Inflectra, Renflexis)

Provider Order Form rev. 5/20/2022



www.vascoinfusion.com
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PATIENT INFORMATION

Patient Name:		DOB:		
Patient Phone:		Patient Email:		
NKDA	Allergies:	Weight lbs/kg:	Height:	
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change	Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

- K50.90 Crohn's/Pediatric Crohn's Disease
- K51.90 Ulcerative Colitis/Pediatric UC
- M06.9 Rheumatoid arthritis
- M45.9 Ankylosing Spondylitis
- L40.50 Psoriatic Arthritis
- L40.0 Plaque Psoriasis
- Other: _____

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg 650mg 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV
- methylprednisolone (Solu-Medrol) 40mg IV 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____

Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Drug: Note: Infliximab (Remicade) has several biosimilars and certain payors require use of specific biosimilars. Indicate your preferred agent (select only one agent below) and allowed alternatives (may select multiple products) if the preferred product is not covered per the patients insurance

- Remicade (infliximab)** Preferred Agent (only select one)
Use if preferred agent is not covered by the patients insurance
- Avsola (infliximab-axxq)** Preferred Agent (only select one)
Use if preferred agent is not covered by the patients insurance
- Inflectra (infliximab-dyyb)** Preferred Agent (only select one)
Use if preferred agent is not covered by the patients insurance
- Renflexis (infliximab-abda)** Preferred Agent (only select one)
Use if preferred agent is not covered by the patients insurance

Dose: 3mg/kg IV other: _____
5mg/kg IV Round up to nearest 100mg from dosage indicated above
7.5mg/kg IV Give exact dose selected above
10mg/kg IV

Frequency:
Initiation therapy: 0, 2 and 6 weeks then every 8 weeks
Initiation therapy: 0, 2 and 6 weeks then every 6 weeks
Initiation therapy: 0, 2 and 6 weeks then every _____ weeks
Maintenance therapy: Every 8 weeks
Maintenance therapy: Every 6 weeks
Maintenance therapy: Every _____ weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order