Infliximab (Remicade, Avsola, Inflectra, Renflexis)

Provider Order Form rev. 5/20/2022

VASCO INFUSION
www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

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

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

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**

☐ **Check here if this is a stat order**