Infliximab (Remicade, Avsola, Inflectra, Renflexis)

Provider Order Form rev. 5/20/2022

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

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Provider Name (Print) **Provider Signature** **Date**

Check here if this is a stat order