

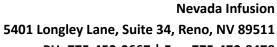
PH: 775-453-0667 | Fax: 775-470-8478

## **Infiximab Order Form**

Patient Name:					DOB:	
Phone:		Address:				
City:	State:	Zip:	Email:			
DIAGNOS	IS:					
Cr	ohn's Disease (ICD-10: K50.)		Ps-	oriatic Arthritis (ICD-	10: L40.50)	
UI-	cerative Colitis (ICD-10: K51.90)			nkylosing Spondylitis		
=	neumatoid Arthritis (ICD-10:M06.9) M06.9)		∐ Ot	ther ICD-10:		
L Pla	aque Psoriasis (ICD-10: L40.0)					
ORDER FO	OR INFLIXIMAB:					
☐ In	nfuse infliximab OR infliximab bi	osimilar as requir	ed by patients	insurance dete	ermination	
**	st(Preferred product to be detern	nined after benefi	ts investigation	)**		
	o NOT Substitute - Continue to 1	reat with the foll	owing Inflixima	ab product:		
	Avsola	Remicad	е		Unbranded Infliximab	
	☐ Inflectra	☐ Renflexis	;			
FREQUEN	CY:					
☐ In	nitial starting dose:	mg/kg IV at	week 0, 2, 6 th	en every 8 wee	eks x 1 year, round to nearest 100mg via	
				•	ek x 1 year, round to nearest 100 mg vial	
					_x 1 year, round to nearest 100 mg vial	
PRE-MED	ICATIONS:					
	✓ Acetaminophen 650mg PC					
	☑ Diphenhydramine 25mg P		10 mg PO			
	☑ Hydrocortisone 100mg IV	•	_	/		
	☐ Additional Pre-Medication		_			
ΜΔΥ ΔΩΝ	MINISTER IF NEEDED FOR ALLERG	SIC REACTION:				
_	evada Infusion Hypersensitivity		et			
	ther:					
ACCESS: P	Peripheral IV, Port, Midline, or PIC	CC line				
FLUSHING	6: 10 mls NS pre/post infusion O	R Heparin 5ml for	<sup>.</sup> port – 100 uni	its/ml		
NURSING:	: Per Nevada Infusion					
LABS ORD	DERS:		Fax results	to:		
PROVIDE	R INFORMATION:					
				NPI:		
Physician	Signature:			 Date:		
Physician Signature: Point of Contact:		Phor	ne:	 Fn	 nail:	

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

\*\*Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. \*\*





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Patient Name:	DOB:
Please Include Required Documentation for Expedited Order	Processing & Insurance Approval:
<ul><li>☐ Signed provider orders (page 1)</li><li>☐ Patient demographic and insurance information</li></ul>	
☐ Patient's current medication list	
☐ Supporting recent clinical notes and H&P (to support p	rimary diagnosis)
$\Box$ Has the patient had a documented contraind or conventional therapy (i.e., MTX, leflunomide) $\Box$ Yes $\Box$ No	lication/intolerance or failed trial of a DMARD, NSAID, 9?
If yes, which drug(s)?	
Humira, Enbrel, Stelara, Cimzia)? □ Yes □ No	olerance or failed trial to at least one biologic (i.e.,
If yes, which drug(s)?	
$\Box$ If psoriasis diagnosis, percent of body surface	e (BSA) involved: %
☐ Include any labs and/or test results to support diagnosi	S
☐ If applicable - Last known biological therapy:	and last date received:
☐ If the patient is switching to biologic therapies, please p to starting Infliximab	perform a wash-out period of weeks prior
☐ Other medical necessity:	
Additional REQUIRED Information:	
☐ TB screening test completed within 12 months - please ☐ Positive OR ☐ Negative	include results
	patitis B antigen and Hepatitis B core antibody total (not

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