Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Infiximab Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Crohn's Disease (ICD-10: K50.)
- ☐ Ulcerative Colitis (ICD-10: K51.90)
- ☐ Rheumatoid Arthritis (ICD-10:M06.9) M06.9)
- ☐ Plaque Psoriasis (ICD-10: L40.0)
- ☐ Psoriatic Arthritis (ICD-10: L40.50)
- ☐ Ankylosing Spondylitis (ICD-10: M45.9
- ☐ Other ICD-10:_____

ORDER FOR INFLIXIMAB:

- ☐ **Infuse infliximab OR infliximab biosimilar as required by patients insurance determination**
  (Preferred product to be determined after benefits investigation)
- ☐ **Do NOT Substitute - Continue to Treat with the following Infliximab product:**
  - ☐ Avsola
  - ☐ Inflectra
  - ☐ Remicade
  - ☐ Renflexis
  - ☐ Unbranded Infliximab

FREQUENCY:

- ☐ **Initial starting dose: _____mg/kg IV** at week 0, 2, 6 then every 8 weeks x 1 year, round to nearest 100mg vial
- ☐ **Maintenance dose:_____mg/kg IV** every _____week x 1 year, round to nearest 100 mg vial
- ☐ **Other Dose:**_____mg/kg IV Frequency: _____x 1 year, round to nearest 100 mg vial

PRE-MEDICATIONS:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

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. **

05/2025

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- ☐ Signed provider orders (page 1)
- ☐ Patient demographic and insurance information
- ☐ Patient's current medication list
- ☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)?

☐ Yes ☐ No

If yes, which drug(s)? _____

☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)?

☐ Yes ☐ No

If yes, which drug(s)? _____

☐ If psoriasis diagnosis, percent of body surface (BSA) involved: _____ %

- ☐ Include any labs and/or test results to support diagnosis
- ☐ If applicable - Last known biological therapy: _____ and last date received: _____
- ☐ If the patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting Infliximab
- ☐ Other medical necessity: _____

Additional REQUIRED Information:

- ☐ TB screening test completed within 12 months - please include results
  - ☐ Positive OR ☐ Negative
- ☐ Hepatitis B screening test completed (this includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - please include results
  - ☐ Positive OR ☐ Negative

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