Infliximab (Remicade, Renflexis, Avsola, Inflectra)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• TB results: If TB results are positive, provide documentation of treatment or medical clearance, and a negative CXR

• Hepatitis B results: If Hepatitis B results are positive, provide documentation of medical clearance

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ K50.00 Crohn's disease of small intestine without complications

☐ K50.10 Crohn's disease of large intestine without complications

☐ K50.90 Crohn's disease, unspecified without complications

☐ K51.00 Ulcerative (chronic) pancolitis without complications

☐ K51.90 Ulcerative colitis, unspecified without complications

☐ M06.9 Rheumatoid arthritis, unspecified

☐ Other:

PRIMARY MEDICATION ORDER

Infliximab (Remicade) or other infliximab product (as required by patient's health plan)

• Infuse over 2 hours via an in-line, sterile, non-pyrogenic, low-protein-binding filter (pore size ≤1.2 micron)

• Flush with 0.9% sodium chloride at infusion completion

• Patient will be eligible for 1-hour infusions after 6 consecutive treatments without reaction. To prohibit rapid infusions, check here ☐

• Dose will be rounded up to nearest 100mg. To prohibit rounding up, check here ☐

• Refill for 12 months unless otherwise noted: _____

DOSE	FREQUENCY
☐ 3 mg/kg	☐ **New Start:** week 0, 2, 6, and then every 8 weeks thereafter
☐ 5 mg/kg	☐ **Maintenance:** every 8 weeks
☐ 7.5 mg/kg	☐ Other: _____
☐ 10 mg/kg	
☐ Other: ____ mg/kg	

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Infliximab

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772