

Infliximab (Remicade, Renflexis, Avsola, Inflectra)

Provider Order Form rev. 8/24/26



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 | ☐ K51.00 Ulcerative (chronic) pancolitis without complications |
| ☐ K50.10 Crohn's disease of large intestine without complications | ☐ K51.90 Ulcerative colitis, unspecified without complications |
| ☐ K50.90 Crohn's disease, 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	

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)

SPECIAL INSTRUCTIONS

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