

LOWCOUNTRY Rheumatology

A Member of Articularis Healthcare Group, Inc.

Please fax completed form, insurance card, and clinical documentation to:
FAX: (843) 793-6181

INFLIXIMAB ORDER DERMATOLOGY

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies NKDA Allergies: _____

Height: _____ Weight: _____

Indication:

L40.5 ___ Psoriatic Arthritis/Arthropathy

L40. ___ Psoriasis

Other _____

<p>DRUG: Avsola Inflectra Remicade Renflexis Unbranded Infliximab</p> <p><input type="checkbox"/> Infliximab-per insurance preferred</p> <p><input type="checkbox"/> Avsola (Infliximab-axxq)</p> <p><input type="checkbox"/> Inflectra (Infliximab-dyyb)</p> <p><input type="checkbox"/> Remicade (Infliximab)</p> <p><input type="checkbox"/> Renflexis (Infliximab-abda)</p> <p><input type="checkbox"/> Unbranded Infliximab</p>	<p>DOSE</p> <p><input type="checkbox"/> _____ mg/Kg</p> <p>FREQUENCY</p> <p><input type="checkbox"/> At weeks 0, 2, 6 then</p> <p><input type="checkbox"/> Every _____ weeks</p>
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PREMEDICATION ORDERS: *not required by PI*

Acetaminophen po: 1000mg 500mg 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Solu-Medrol: 62.5mg IVP 100mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
 - Insurance card(s) – copy of front & back
 - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____