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 _____

DRUG: Avsola | Inflectra | Remicade | Renflexis | Unbranded Infliximab
☐ Infliximab-per insurance preferred
☐ Avsola (Infliximab-axxq)
☐ Inflectra (Infliximab-dyyb)
☐ Remicade (Infliximab)
☐ Renflexis (Infliximab-abda)
☐ Unbranded Infliximab

DOSE
☐ _____mg/Kg
FREQUENCY
☐ At weeks 0, 2, 6 then
☐ Every _____ weeks

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 <u>ALL</u> 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 ☐ Lipids ☐ TB ☐ Hep B Other: _____