

# 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 RHEUMATOLOGY

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:**

M05.\_\_\_\_ Rheumatoid Arthritis with Rheumatoid Factor

K06.\_\_\_\_ Rheumatoid Arthritis without Rheumatoid Factor

M45.\_\_\_\_ Ankylosing Spondylitis

D86.0\_\_ Sarcoidosis of the Lung

L40.5\_\_ Psoriatic Arthropathy

Other \_\_\_\_\_

<p><b>DRUG:</b> 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><b>DOSE</b></p> <p><input type="checkbox"/> _____mg/Kg</p> <p><b>FREQUENCY</b></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: \_\_\_\_\_