Infliximab (Remicade, Renflexis, Unbranded Infliximab)

Provider Order Form rev. 7/29/2025

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ K50. ___: Moderate to severe Crohn's disease ☐ K51. ___: Moderate to severe ulcerative colitis

☐ L40. ___: Psoriasis ☐ M05. ___: Rheumatoid arthritis

☐ M06. ___: Rheumatoid arthritis ☐ M45. ___: Ankylosing spondylitis

☐ Other: Description:

THERAPY ADMINISTRATION *(Select one)*

☐ Infuse infliximab (Remicade) OR infliximab biosimilar as required by patient's insurance.

☐ Infuse this infliximab product (subject to prior authorization)

_____

DOSING *(Select one)*

☐ _____ mg IV

☐ _____ mg/kg x _____ kg IV = _____ mg

☑ Mix in 250ml of NS for doses less than 999mg. Mix in 500ml NS for doses greater than 1000mg.

FREQUENCY *(Choose one)*

☐ Week 0, 2, 6, and then every 8 weeks

☐ Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC w/ diff ☐ at each dose ☐ every: _____

☐ CMP ☐ at each dose ☐ every: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs/symptoms of illness or active infection/cough, night sweats, or weight loss
- Planned/recent surgical procedures or recent live vaccinations, TB, or Hep B positive.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, biologic agent and steroids, colonoscopy or BSA of affected skin (by indication)

Required Labs: Include negative Hepatitis B within 3 years and Negative TB within 12 months.

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.