

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card front and back (required)

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City/ST/Zip: _____
Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm

DIAGNOSIS*

ICD-10 CODE (required)

Please complete 2nd and 3rd digits to complete ICD-10 for billing

- K50.00 _____ Crohn's Disease of Small Intestine without Complications
- K50.10 _____ Crohn's Disease of Large Intestine without Complications
- K50.80 _____ Crohn's Disease of Both Small and Ig Int w/o Complications
- K51.00 _____ Ulcerative (Chronic) Pancolitis without Complications
- K51.20 _____ Ulcerative (Chronic) Proctitis without Complications
- Other: _____, ICD-10 _____

INFUSION ORDERS

MEDICATION

Infliximab and biosimilars
 Avsola® Remicade®
 Inflectra® Renflexis®

DOSE

_____ mg (5 mg/kg)
 _____ mg (10 mg/kg)
 _____ mg (_____ mg/kg)

DIRECTIONS/DURATION

Initial: Infuse IV over 2 hours at Weeks 0, 2, 6, then every 8 weeks x 1 year
 Maintenance: Infuse IV over 2 hours every 8 weeks x 1 year
 Maintenance: Infuse IV over 2 hours every _____ weeks x 1 year

Is patient currently receiving therapy above from another facility? NO YES
If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: Infusion Center Referring Physician
 No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____ ESR q _____ LFTs q _____ Other: _____

PRE-MEDICATION ORDERS:

No premeds ordered at this time Diphenhydramine 25mg PO Other: _____
 Acetaminophen 650mg PO Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IV

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
Physician Name: _____ Provider NPI: _____ Specialty: _____
Address: _____ City/ST/Zip: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS (required)

- TB Screening for Cimzia, Entyvio, infliximab biosimilars, Omvoh, Skyrizi, Stelara and Tremfya (submit results from within 12 months to start and annually to continue therapy)
 - Annual TB screening to be done by: Infusion Center Referring Physician
- Hepatitis B Screening for Cimzia and infliximab biosimilars (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
 - Continuation labs to be done by: Infusion Center Referring Physician

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____