Infliximab for Rheumatic Diseases

Referring Physician Orders Rev. 4/2026

Please fax completed referral form & all required documents to 770-618-9617

CPS INFUSION

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***

☐ M05._____ Rheumatoid Arthritis with Rheumatoid factor
☐ M06._____ Rheumatoid Arthritis without Rheumatoid factor
☐ M45._____ Ankylosing Spondylitis
☐ D86._____ Sarcoidosis
☐ L40.5_____ Psoriatic Arthopathy
☐ Other: _____, ICD-10 _____

INFUSION ORDERS

MEDICATION

Infliximab and biosimilars

☐ Avsola®
☐ Inflectra®
☐ Remicade®
☐ Renflexis®

DOSE

☐ _____ mg (3 mg/kg)
☐ _____ mg (5 mg/kg)
☐ _____ mg (____ mg/kg)

DIRECTIONS/DURATION

☐ Initial: Unfuse IV over 2 hours at Weeks 0, 2, 6, then every _____ 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
☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV
☐ Other: _____

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 Actemra, Cimzia, Cosentyx, infliximab biosimilars, Orencia, and Simponi Aria (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician

Hepatitis B Screening for Cimzia, infliximab biosimilars, Orencia, Simponi Aria, tocilizimab biosimilars and Rituxan (submit results to start therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For SLE: ☐ Autoantibody test (ANA, anti-dsDNA)

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: _____
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