Infliximab *(Remicade or other infliximab product as required by patient's health plan)*

IVX HEALTH

Provider Order Form *rev. 3/27/2024*

PATIENT INFORMATION

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

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

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

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ TB status & date (list results here & attach clinicals)
_____

☑ Hepatitis B status & date (list results here & attach clinicals)
_____

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 06.07.2023)

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☑ Infliximab (Remicade) or other infliximab product (as required by patient's health plan)
NOTE: (Infliximab products include: Remicade, Unbranded Infliximab, Avsola, Inflectra, and Renflexis)

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg
☐ Other: _____
☐ Round up to nearest 100mg **OR** ☐ Give exact dose

Frequency: ☐ induction: week 0, 2, 6, and then every 8 weeks /
☐ maintenance: every 8 weeks / ☐ other:
_____

Infusion rate: Select one below. Patients who tolerate induction and the initial maintenance infusion without severe reaction will be eligible for 1 hour infusion.

☐ Infuse over 2 hours (standard rate)

☐ Infuse over 1 hour (when patient eligible)

☑ Flush with 0.9% sodium chloride at infusion completion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

*Perform test for latent TB; if positive, start treatment for TB prior to starting treatment. Monitor all patients for active TB during treatment, even if initial latent TB test is negative. *Patients should be tested for HBV infection before initiating TNF blocker therapy, including REMICADE. For patients who test positive for hepatitis B surface antigen, consultation with a physician with expertise in the treatment of hepatitis B is recommended.

Provider Name (Print) **Provider Signature** **Date**

FAX NUMBERS

☐ AUSTIN: 512-772-2824	☐ CONNECTICUT: 860-955-1532	☐ INDIANAPOLIS: 844-983-2028	☐ NORTH CENTRAL FL: 352-756-4191	☐ RALEIGH: 919-287-2551
☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ JACKSONVILLE: 904-212-2338	☐ NORTH JERSEY: 551-227-2823	☐ SAN ANTONIO: 726-238-9950
☐ CHARLOTTE: 336-663-0143	☐ DELAWARE: 302-596-8553	☐ KANSAS CITY: 844-900-1292	☐ NORTHWEST AR: 888-615-1445	☐ SARASOTA: 941-870-6550
☐ CHICAGO: 312-253-7244	☐ EAST TN: 615-425-7427	☐ LAKELAND: 863-316-3910	☐ ORLANDO: 844-946-0867	☐ SOUTH JERSEY: 856-519-5309
☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ LITTLE ROCK: 501-451-5644	☐ PALM BEACH: 561-768-9044	☐ SOUTHWEST FL: 813-283-9144
☐ COLUMBUS: 844-627-2675	☐ HARRISBURG: 844-859-4235	☐ MIAMI: 786-744-5687	☐ PHILADELPHIA: 844-820-9641	☐ TAMPA: 844-946-0849
	☐ HOUSTON: 832-631-9595	☐ MIDDLE TN: 888-615-1445	☐ PIEDMONT TRIAD: 336-790-2200	☐ WEST TN: 888-615-1445