CURBSIDE
INFUSION SERVICES

INFLIXIMAB

(Including Remicade and biosimilars: Renflexis, Avsola)

Fax to 713-489-9955
Email:Referrals@curbsideinfusion.com

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Medication List
- Tried/Failed Therapies
- Negative TB Results

LABS: PLEASE INCLUDE FREQUENCY

Labs patient should be reminded to have drawn ____

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified without complications
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.90 Ulcerative colitis, unspecified without complications
☐ M06.9 Rheumatoid arthritis, unspecified
☐ Other: ____

PRE-MEDICATIONS

☑ Per infusion clinic protocol, there are no recommended standard pre-meds for Infliximab
☐ Provider Prescribed: ____

PRIMARY MEDICATION ORDER

*Remicade or biosimilar (Renflexis, Avsola) may be used according to payer guidelines
*To prohibit auto-substitution, please indicate specific brand required ______________________________

☐ Infliximab 3 mg/kg (_______mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab 5 mg/kg (_______mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab 10 mg/kg (_______mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Infliximab ________mg/kg (_______mg) IV every _______ weeks
☐ Other: ____

* First Dose: Y N

Refill x12 months unless otherwise noted:____________________________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Curbside Infusion Ventures' protocol
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Curbside Infusion Venture protocol
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

____ ____________________
Provider Signature Date

**The information contained in this document will become a legal prescription. Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements. Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.