

INFLIXIMAB

(Including Remicade and biosimilars: Renflexis, Avsola)

Fax to 281-406-1047 Office 281-406-1046

				Email:Referrals@cu	urbsideinfusion.com
PATIENT DEMOG	RAPHICS				
Patient Name:			Patient's Phone I	Number:	
Date of Birth:			Address:		
Allergies: See List	NKDA□		City, State, Zip:		
Weight:	lbs or	kg	Patient's Email:		
REQUIRED DOC	JMENTATION				
Insurance Card	History & Physical	 Patient Demographics 	Medication List	Tried/Failed Therapies	 Negative TB Results
LABS: PLEASE II	NCLUDE FREQUEN	CY			
Labs patient should	be reminded to have	drawn			
PRIMARY DIAGN	OSIS				
☐ 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-MEDICATIO	NS				
		o recommended standard		nab	
PRIMARY MEDIC	ATION ORDER				
		la) may be used according cate specific brand required			
☐ Infliximab 5 mg/kg☐ Infliximab 10 mg/kg☐ Infliximab	g (mg) IV at kg (mg) IV a	weeks 0, 2, 6, and every 8 weeks 0, 2, 6, and every 8 tweeks 0, 2, 6, and every 8 g) IV every weeks	weeks thereafter weeks thereafter		
· First Dose: Y	N				
Refill x12 months unoted:					
✓ Start PIV/ACCES	S CVC	vice per Curbside Infusion \ ine care orders if checking	·		
ADVERSE REAC	TION & ANAPHYLA	XIS ORDERS			
	infusion reaction and Venture protocol	anaphylaxis medications pe	r □ Other: P	lease fax other reaction ord	ders if checking this box
PROVIDER INFO	RMATION: PLEASE	CHECK PREFERRED FO	RM OF COMMUNIC	CATION	
Provider Name:			Office Contact:		
Address:	ddress:		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.