CURBSIDE INFUSION SERVICES

INFLIXIMAB

(Including Remicade and biosimilars: Renflexis, Avsola)

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