Infliximab

(including Remicade and biosimilars: Renflexis, Avsola, Inflectra)

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

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

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

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

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

Dermatology

☐ L40.5_____ Psoriatic Arthritis/Arthopathy
☐ L40._____ Psoriasis

Gastroenterology

☐ K50.0____ Crohn's Disease, Small Intestine
☐ K50.1____ Crohn's Disease, Large Intestine
☐ K50.8____ Crohn's Disease, Small & Large Intestine
☐ K50.9____ Crohn's Disease, Unspecified
☐ K51.8____ Other Ulcerative Colitis, Chronic
☐ K51.5____ Left Sided - Ulcerative Colitis, Chronic
☐ K51.0____ Universal Ulcerative Pancolitis, Chronic
☐ K51.9____ Ulcerative Colitis, Unspecified
☐ K60.3 Anal Fistula
☐ K63.2 Fistula of Intestine

Rheumatology

☐ M05._____ Rheumatoid Arthritis, w/ Rheumatoid Factor
☐ M06._____ Rheumatoid Arthritis, w/o Rheumatoid Factor
☐ L40.5 _____ Psoriatic Arthtritis/Arthropathy
☐ M45._____ Ankylosing SPondylitis
☐ D86.0 Sarcoidosis of the Lung
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Negative TB Results within 3 years and 12 months
☐ Other: _____

Infliximab IV: (Select one):

☐ Remicade (Infliximab) **OR** Biosimilar as dictated by patient's insurance. (AIC will determine appropriate product based)
☐ Inflixmab Product: ☐ **Remicade** ☐ **Avsola** ☐ **Inflectra** ☐ **Renflexis** (DO NOT SUBSTITUTE)

Loading Dose:

☐ Infuse 3 mg/kg at weeks 0, 2, and 6 ☐ Infuse 5 mg/kg at weeks 0, 2, and 6 ☐ Infuse _____ mg or _____ mg/kg at weeks 0, 2, and 6

Maintenance Dose:

☐ Infuse 3 mg/kg every 8 weeks for one year ☐ Infuse 5 mg/kg every 8 weeks for one year
☐ Infuse _____mg or _____ mg/kg every _____ weeks for one year

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.
Special Instructions: _____

Refills: ☐ zero ☐ for 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

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

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc)**: F: 469.305.2361 P: 972.865.4454**