Infliximab Product Order Form

Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Demographics

Patient Name: _____
DOB: _____
Phone Number: _____
Allergies: _____
Patient Height: _____

Ordering Provider: _____
NPI: _____
Primary Care Provider: _____
Insurance Information: _____
Patient Weight (lbs)_____

Referral Status

☐ New Referral
☐ Dose or Frequency Change
☐ Order Renewal

Has the patient been treated for this condition previously?
☐ No ☐ Yes, medication(s): _____
_____

Diagnosis & Required Information

Diagnosis & ICD-10:

☐ Moderate to Severe Crohn's Disease - K50. 90
☐ Moderate to Severe Ulcerative Colitis - K51.9
☐ Plaque Psoriasis - L40.0
☐ Psoriatic Arthritis - L40.52
☐ Rheumatoid Arthritis - M06.9
☐ Ankylosing Spondylitis - M45.9
☐ Other: _____

Required Information:

☐ Patient Face Sheet
☐ Clinical/Progress Note
☐ Hepatitis B Test Results: HBsAG, Total HepB Core Antibody
☐ Labs/Tests supporting diagnosis
☐ TB Test Results: Please send chest x- ray results if TB is indeterminant

Medication Order

Pre-Medications:

☐ Acetaminophen (Tylenol) tablet, oral, ONCE
  ☐ 650 mg
  ☐ Other: _____

☐ Cetirizine (Zyrtec) tablet, oral, ONCE
  ☐ 10 mg

☐ Famotidine, IV
  ☐ 40 mg

☐ Methylprednisolone sodium succinate (Solu-Medrol) IV, ONCE
  ☐ _____ mg
(Choose if patient has required IV steroids for a reaction during prior TNF-alpha inhibitor infusion)

☐Other:_____

Drug:

☐ Infliximab or Biosimilar *(Oregon Specialty Infusion will determine product based upon patient's insurance & benefits investigation)*
— OR —

☐ Infuse this product only: _____

☐ Renewal order, please continue with current Infliximab product
Subject to prior authorization. OSG formulary products include: Avsola, Renflexis, Remicade

Dose:

☐ 5 mg/kg IV
☐ Other: _____

Frequency:

☐ Induction: weekly x ____ weeks ☐ Maintenance: Every ___ weeks ___ months
☐ Induction: Day 1, 15, & 43 ☐ Other: _____

Labs:

☐ Complete Metabolic Panel, Routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months
☐ CBC with Differential, Routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months
☐ Other: _____

Physician's Signature: _____ **Date:** _____

Provider Name: _____ **Office Phone:** _____ **Office Fax:** _____

Fax completed form to (503) 540-3105

Questions? Call us at (503) 540-9999

Updated 6/2024