Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Infliximab Order Form (infliximab)

Fax To: 503-540-3105

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht:_____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

DERMATOLOGY

☐ L40.5____ Psoriatic Arthritis
☐ L40.0 Plaque Psoriasis
☐ Other: _____

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
☐ K51.0_____Universal Ulcerative Colitis, Chronic
☐ K51.9_____Ulcerative Colitis, Unspecified

RHEUMATOLOGY

☐ M05. _____ Rheumatoid Arthritis w/Rheumatoid Factor
☐ M06. _____ Rheumatoid Arthritis w/o Rheumatoid Factor
☐ L40.5 _____ Psoriatic Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ D86.0 Sarcoidosis of the Lung

REQUIRED: Demographics & Most Recent: H&P, clinical notes, labs & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

PRESCRIPTION

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Cetirizine 10 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IV
☐ Loratadine 10 mg PO
☐ Other: _____
☐ Acetaminophen: _____ mg PO
☐ Dexamethasone: _____ mg IV
☐ Famotidine: _____ mg IV
☐ Methylprednisolone: _____ mg IV
☐ Ondansetron 4 mg IV

Lab Orders

Required: Negative TB, annually
☐ CBC w/diff: every _____ ☐ weeks ☐ months
☐ CMP: every _____ ☐ weeks ☐ months
☐ CRP: every _____ ☐ weeks ☐ months
☐ ESR: every _____ ☐ weeks ☐ months
☐ B12/Folate: every _____ ☐ weeks ☐ months
☐ Other: _____

Drug

☐ Infliximab **OR** Biosimilar as dictated by patient's insurance*
Oregon Specialty Infusion will determine appropriate product based upon benefit investigation
OR
☐ Infliximab product _____ (DO NOT SUBSTITUTE)

Loading Dose (SELECT ONE)

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

Maintenance Dose (SELECT ONE)

☐ **IV:** Infuse 3 mg/kg every 8 weeks x 1 year
☐ **IV:** Infuse 5 mg/kg every 8 weeks x 1 year
☐ **IV:** Infuse _____ mg or _____ mg/kg every _____ weeks x 1 year

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose: _____
_____

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #_____ Specialty: _____

Office phone #: _____ Office Fax #: _____