



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
- L73.2 Hidradenitis Suppurativa

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

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
- K51.8 Other Ulcerative Colitis, Chronic
- K51.5 Left sided – Ulcerative Colitis
- K51.0 Universal Ulcerative Colitis, Chronic
- K51.9 Ulcerative Colitis, Unspecified

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*
- 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/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 #: _____