Provider Order Form

REMICADE (INFLIXIMAB BIOSIMILARS)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Rheumatoid Arthritis M05. _____ ☐ Crohn's Disease K50. _____ ☐ Psoriasis L40. _____

☐ Ankylosing Spondylitis M45. _____ ☐ Ulcerative Colitis K51. _____ ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Remicade (Infliximab), IV Mix in 250ml 0.9% sodium chloride, (use in line filter 1.2 micron or less)	☐ 3 mg/kg ☐ 5 mg/kg ☐ 10 mg/kg	☐ week 0, 2, 6 and then every 8 weeks ☐ every 8 weeks
☐ Infliximab Biosimilar: ☐ Inflectra ☐ Avsola ☐ Renflexis	Other Dose: _____	

Refills ☐ Zero ☐ 12 months ☐ _____. Order valid for 1 year unless otherwise stated. _____

☒ Infuse over 2 hours.

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ CRP	☐ at each dose	☐ every _____
☐ Other _____	☐ at each dose	☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ TB status results ☐ Hepatitis B status results

_____ _____

Provider Signature Date