REVITALIZE
INFUSION CENTER

Infliximab

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

- ☐ Rheumatoid Arthritis — ICD-10 Code: M0____.____
- ☐ Crohn's Disease — ICD-10 Code: K50._____
- ☐ Ulcerative Colitis — ICD-10 Code: K51._____
- ☐ Ankylosing Spondylitis — ICD-10 Code: M45.0_____
- ☐ Other_____ — ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Include previously tried and failed therapies
- Required Information:
  - TB screening results
  - Hepatitis B virus screening

Height: _____

Weight: _____

Infliximab Orders:

☐ Infliximab OR infliximab biosimilar (as required by patient's insurance)

☐ Do not substitute. Administer Brand: _____

Dose: _____ mg/kg (_____ mg)

Frequency: ☐ 0, 2, 6 weeks then every 8 weeks for one year

☐ every _____ weeks for one year

☐ Other: _____

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 50 mg IV ☐ Methylprednisolone 125 mg IV

☐ Loratadine 10 mg PO ☐ Cetirizine 10 mg PO

☐ Other: _____

Lab Orders:

☐ CBC with Diff every 6 months ☐ CMP every 6 months ☐ Other: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize | Revitalize Locations | InfusionPlus