

Patient Information

Name: _____ DOB: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Weight: _____ lbs kgs
Allergies: NKDA _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Medication List | Negative TB Results
Tried and Failed Therapies (including duration)

Primary Diagnosis

- | | |
|--|---|
| <input type="checkbox"/> K50.00 Crohn's disease of small intestine without complications | <input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified |
| <input type="checkbox"/> K50.90 Crohn's disease, unspecified without complications | <input type="checkbox"/> M06.9 Rheumatoid arthritis, unspecified |
| <input type="checkbox"/> K51.00 Ulcerative pancolitis (chronic) without complications | <input type="checkbox"/> M45.9 Ankylosing spondylitis of unspecified sites in spine |
| <input type="checkbox"/> K51.90 Ulcerative colitis, unspecified without complications | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> L40.0 Psoriasis vulgaris | |

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

- Per infusion clinic protocol, there are no recommended standard pre-meds for Infliximab
 Provider Prescribed: _____

Primary Medication Order

**Remicade or biosimilar (Renflexis, Avsola, Inflectra) may be used according to payer guidelines*
**To prohibit auto-substitution, please indicate specific brand required _____*

- Infliximab 3mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
 Infliximab 5mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
 Infliximab 10mg/kg (_____mg) IV at weeks 0, 2, 6, and every 8 weeks thereafter
 Infliximab _____mg/kg (_____mg) IV every _____ weeks
 Other: _____

- *Initial calculated dose will become fixed dose throughout treatment. Check here to adjust dose per appointment
*Dose will be rounded to nearest vial size (See flexcareinfusion.com for rounding protocol). To prohibit dose rounding, check here
*Patient will be eligible for 1hr infusions after 6 consecutive treatments without reaction. To prohibit rapid infusions, check here
First Dose: Yes No Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

- Start PIV/ACCESS CVC Flush device per BluHaven Health's protocol (see BluHaven.com for policy)
 Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

- Administer acute infusion reaction and anaphylaxis medications per BluHaven Health's protocol (see BluHaven.com for policy)
 Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____
Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature _____

Date _____