Infliximab

Remicade, Inflectra, Avsola, Renflexis

Provider Order Form Revised 10/29/2025

PROVIDERS: Please include the following information to expedite the order:
Patient Demographic, most recent Office Visit Note, Insurance Information, TB Results, Recent Labs

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: 02/10/2026 Patient Name: Sam Test DOB: 10/10/2010

ICD-10 code: ■K50._____ ☐K51._____ ☐M06.00 ☐M05.60 ☐M05.70 ☐M45.9 ☐L40.50 ☐L40.0

ICD-10 Description: Crohn's disease of small intestine

Other ICD-10 code and description:_____

☐NKDA Allergies: sulfa ____Weight (lb/kg) 125 lb Height 5'5"

Patient Status: ■ New to Therapy ☐New to Therapy Last Treatment Date:_____ Next Due Date:_____

PROVIDER INFORMATION

Referral Coordinator Name:_____ Referral Coordinator Email:_____

Ordering Provider: Wile E Coyote Provider NPI:_____

Referring Practice Name: GI Associates Phone: 555-1212 Fax:_____

Practice Address:_____ City:_____ State:_____Zip:_____

NURSING

☒ TB status and date (list results and attach clinicals)

_____

☒ Hepatitis B status and date (list results and attach clinicals)

☒ Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI

☒ Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

LABORATORY ORDERS

■ CBC ■ at each dose ☐ every_____

☐ CMP ☐ at each dose ☐ every_____

☐ CRP ☐ at each dose ☐ every_____

■ Other: Infliximab level prior to each dose when at maintenance cycle

☐ Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

Not usually indicated for this medication.

■ acetaminophen (Tylenol) ■500 mg/ ☐650 mg/ ☐1000 mg PO

☐ cetirizine (Zyrtec) 10 mg PO

☐ loratadine (Claritin) 10 mg PO

■ diphenhydramine (Benadryl) ■25 mg/ ☐50 mg ☐PO/■IV

☐ methylprednisolone (Solu-Medrol) ☐ 40 mg/ ☐ 125 mg IV

☐ hydrocortisone (Solu-Cortef) 100 mg IV

☐ Other:_____

Dose:_____ Route:_____

THERAPY ADMINISTRATION

☒ **Infliximab (Remicade)** or other infliximab product as required by patient's health plan.

- **Dose:** ☐ 3mg/kg / ■ 5mg/kg / ☐ 7.5mg/kg / ☐ 10mg/kg
  ☐ Other:_____
- **Frequency:**
  ■ Induction: week 0, 2, 6, and then every 8 weeks /
  ☐ Maintenance: every 8 weeks /
  ☐ Other:_____
- **Route:** ☒ Intravenous
- **Infusion rate** (select below):
  ■ Infuse over 2 hours (standard rate)
  ☐ Rapid infusion over 1 hour (patients who tolerate induction and initial maintenance infusion without adverse reaction will be eligible for 1 hour infusion)

☒ Flush with 0.9% sodium chloride after infusion completion

- Refills: ☐ Zero/ ■ for 12 months/ ☐ Other:_____
  (If not indicated, order will expire one year from date signed)

To ensure a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Redeemer Infusion is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS

☐ Please check this box if you DO NOT authorize Redeemer Health Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

Wile E Coyote MD _____ 2/10/2026

Provider Name (Print) Provider Signature Date