TEXASINFUSION

1935 W. State Street STE 103
Garland, TX 75042
Ph: 972-372-9787
Fx: 972-787-1492

INFLIXIMAB INFUSION ORDER FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Weight: _____kg ; Height _____inches

DIAGNOSIS AND ICD 10 CODE			
☐ Chron's Disease	ICD 10 Code: _____	☐ Ankylosing Spondylitis	ICD 10 Code: _____
☐ Ulcerative Colitis	ICD 10 Code: _____	☐ Psoriasis:BSA % _____	ICD 10 Code: _____
☐ Rheumatoid Arthritis	ICD 10 Code: _____	☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics	☐ Labs: CBC w/ diff, CMP, CRP, ESR,
☐ Insurance card with provider phone number	☐ YEARLY: Hep B antigen AND Quantiferon TB gold

List Tried & Failed Therapies, including duration of treatment:
1)
2)
3)

PA Guidance: Failed DMARD, NSAID, MTX, leflunomide. Failed injectable biologics: Humira, Enbrel, Stelara, Cimzia

ORDERS	
Dose _____ mg/kg in 250mL or 500mL 0.9% sodium chloride.	☐ **Induction** dose week 0, 2, 6 weeks. ☐ **Maintenance** dose every 8 weeks (OR every _____ weeks) ☐ Normal saline Flushes 10ml as needed (max 10 per infusion) ☐ PREMEDS: _____
Infusion orders	1. RN to start, pause, or discontinue peripheral or central venus access device as needed 2. Flush IV line with 10-20ml saline before and after each medication dose or as needed 3. Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed 4. Dispense DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 500mL 0.9% NS)	
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	

PRESCRIBER INFORMATION		
Prescriber Name:	NPI #:	
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 1-2-2023