Infliximab Enrollment Form

Date: _____
Patient Name: _____
Date of Birth: _____

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information:

Last Infusion Date: _____ Next Infusion Date: _____

DIAGNOSIS

Description

◯ Crohn's Disease ◯ Rheumatoid Arthritis ◯ Psoriasis
◯ Ankylosing Spondylitis ◯ Ulcerative Colitis ◯ Psoriatic Arthritis
◯ Other _____

ICD-10 Code

◯ K50.0 ◯ M06.9 ◯ L40.9 ◯ M45 ◯ K51.9 ◯ L40.5
◯ Other _____

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

◯ This signed order form
◯ Patient Demographics and Insurance Information
◯ History and Physical
◯ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient weight: _____ Lbs Height: _____ Inches BSA: _____ Allergies: _____

Line Access: ◯ PIV ◯ PICC (SL DL TL) ◯ PORT ◯ Sub-Q

MEDICATION (dosage may be rounded to the nearest vial size)	DOSE	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITATE (check for ContinuumRx to draw)
◯ Remicade ◯ Inflectra ◯ Renflexis ◯ Avsola	◯ 100mg Vial	◯ **Initiation** - Infuse _____ mg/kg IV over 2-3 hours at weeks 0, 2, and 6 ◯ **Maintenance** - Infuse _____ mg/kg IV over 2-3 hours every _____ weeks	◯ x1 year ◯ Other: _____	◯ Hepatitis B Panel ◯ CBC w/ Differential ◯ TB QuantiFERON Gold

LAB ORDERS - To be drawn by ContinuumRx

Order

◯ CBC w/ Differential ◯ CBC w/o Differential ◯ CMP ◯ BMP ◯ CRP ◯ Sed Rate ◯ Calcium ◯ Tb QuantiFERON Gold
◯ Hepatitis Panel ◯ Other _____

Frequency: _____

IV PRE-MEDICATIONS - *RECOMMENDED

Premedication(s)

◯ Diphenhydramine 25-50 mg po - 25mg #2 per dose
◯ Acetaminophen 325-650 mg po - 325mg #2 per dose
◯ Methylprednisolone _____ mg IV over _____ mins
◯ Other: _____

Ancillary orders will include:

NaCl 0.9% 5-10ml IV before and after infusion
Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
All infusion supplies necessary to administer the medication
Anaphylaxis Kit

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician signature: _____ Date: _____

Physician name: (Please print) _____

Phone: _____ Fax: _____ License #: _____ NPI #: _____

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