

Infliximab



For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (724) 240-1586

Phone (724) 510-3702

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight: Lbs Kg
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State Zip
Office Contact:	Email:
Office phone:	Office fax:

4. DIAGNOSIS INFORMATION (ICD 10 Code Required) - Hep B and TB required prior to initial infusion

Rheumatoid Arthritis () Ankylosing Spondylitis () Plaque Psoriasis ()
Psoriatic Arthritis () Crohn's Disease () Ulcerative Colitis () Other: _____

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

Use preferred Infliximab product per payer recommendations

Product name: _____
To be completed by Horizon Infusions Horizon Clinical Signature Dated

Dose: 3mg/kg 5mg/kg 7.5mg/kg 10mg/kg
Other: _____
Round up to nearest 100mg OR Give exact dose
(If not indicated, will round)

Frequency: Induction: week 0, 2, 6, and then every 8 wks
Maintenance: every 8 weeks other: _____

Infusion Rate: Select one below. Patients who tolerate induction and the initial maintenance infusion without severe reaction will be eligible for 1 hour infusion

Infuse over 2 hours (standard rate)
Infuse over 1 hour (when patient eligible)

Vitals and Anaphylaxis Mgmt per HI Protocol

PRE-MEDICATIONS N/A
Acetaminophen 500mg 650mg 1000mg
Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
Diphenhydramine (Benadryl) 25mg 50mg
PO IV (requires driver)
Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
Prednisone _____ mg PO
Other _____
POST-MEDICATIONS N/A
Acetaminophen 500mg 650mg 1000mg
Prednisone _____ mg PO
Other _____

6. LABS

CBC w/Diff Each Infusion Other Frequency (specify): _____
CRP Each Infusion Other Frequency (specify): _____
CMP Each Infusion Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____
Other (specify): _____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE