arise infusion
THERAPY SERVICES
A DIVISION OF ARTHRITIS AND RHEUMATISM ASSOCIATES, PC

**Fax To:** 301-424-3590
**Have a Question? Call:** 240-514-5000

# INFLIXIMAB ORDER FORM

## REFERRAL TYPE

☐ New Referral ☐ Order Renewal ☐ Restart ☐ Frequency Change ☐ Dosage Change

## PREFERRED LOCATION

| | | |
|---|---|---|
| ☐ 2730 University Blvd. West \| Suite 714<br>Wheaton, MD 20902 | ☐ 14995 Shady Grove Road \| Suite 250<br>Rockville, MD 20850 | ☐ 5454 Wisconsin Avenue \| Suite 600<br>Chevy Chase, MD 20815 |
| ☐ 18111 Prince Philip Drive \| Suite 323<br>Olney, MD 20832 | ☐ 71 Thomas Johnson Drive<br>Frederick, MD 21702 | ☐ 2021 K Street, NW \| Suite 300<br>Washington, DC 20006 |
| | ☐ 8270 Willow Oaks Corporate Drive \| Suite 150<br>Fairfax, VA 22031 | |

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name: | DOB: | Email: |
| Address: | Weight: KG LBS | Phone: |

## REFERRING PHYSICIAN INFORMATION

| | | |
|---|---|---|
| Name: | | NPI: |
| Office Contact Name: | Phone: | Fax: |
| Address: | | |

## INFLIXIMAB ORDER

***OFF-LABEL diagnosis, dose and frequency are subject to medical review and approval.***

**Dosing/Frequency:**

**Preferred Product:** ☐ None ☐ Inflectra ☐ Remicade ☐ Renflexis

☐ Initial Dose: _____ mg/kg IV on 0, 2 and 6 weeks, then every _____ weeks

☐ Maintenance Dose: _____ mg/kg IV every _____ weeks

**Diagnosis:**

☐ K50.10—Crohn's disease of large intestine w/o complications
☐ K50.90—Crohn's disease, unspecified, w/o complications
☐ K51.00—Other ulcerative colitis w/o complications
☐ K51.90—Ulcerative colitis, unspecified, w/o complications
☐ L40.51—Distal interphalangeal psoriatic arthropathy
☐ L40.59—Other psoriatic arthropathy
☐ M05.69—Rheumatoid arthritis of multiple sites with involvement of other organs and systems
☐ M05.79—Rheumatoid arthritis with rheumatoid factor of multiple sites w/o organ or systems involvement
☐ M05.89—Other rheumatoid arthritis with rheumatoid factor of multiple sites
☐ M06.09—Rheumatoid arthritis w/o rheumatoid factor, multiple sites
☐ M06.89—Other specified rheumatoid arthritis, multiple sites

☐ Other Diagnosis: ICD-10 Code (Required):

Special Instructions:

| | |
|---|---|
| Physicians Signature: | Date: ***(Order is Valid for One Year)*** |

## REQUIRED DOCUMENTATION

**Please fax the following documents and records:**

- Patient Demographics
- Two most recent office notes (Supporting the DX and treatment ordered)
- Most recent labs that include values for:
  - CMP, CBC, HBV Surface Antigen
  - TB Screening (PPD, QFT Gold or Tspot) or recent chest x-ray
- Copy of the patient's insurance card(s) – front and back
- Medication History
- For continuation of treatment, include the last infusion note

***We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.***