

INFLIXIMAB ORDER FORM

REFERRAL TYPE				
<input type="checkbox"/> New Referral	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Restart	<input type="checkbox"/> Frequency Change	<input type="checkbox"/> Dosage Change
PREFERRED LOCATION				
<input type="checkbox"/> 2730 University Blvd. West Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue Suite 600 Chevy Chase, MD 20815		
<input type="checkbox"/> 18111 Prince Philip Drive Suite 323 Olney, MD 20832	<input type="checkbox"/> 71 Thomas Johnson Drive Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW Suite 300 Washington, DC 20006		
		<input type="checkbox"/> 8270 Willow Oaks Corporate Drive Suite 150 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				
<i>OFF-LABEL diagnosis, dose and frequency are subject to medical review and approval.</i>				
Dosing/Frequency:		Preferred Product: <input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis		
<input type="checkbox"/> Maintenance Dose: _____ mg/kg IV every _____ weeks				
Diagnosis:				
<input type="checkbox"/> K50.10—Crohn's disease of large intestine w/o complications		<input type="checkbox"/> L40.51—Distal interphalangeal psoriatic arthropathy		
<input type="checkbox"/> K50.90—Crohn's disease, unspecified, w/o complications		<input type="checkbox"/> L40.59—Other psoriatic arthropathy		
<input type="checkbox"/> K51.00—Other ulcerative colitis w/o complications				
<input type="checkbox"/> K51.90—Ulcerative colitis, unspecified, w/o complications				
<input type="checkbox"/> M05.69—Rheumatoid arthritis of multiple sites with involvement of other organs and systems				
<input type="checkbox"/> M05.79—Rheumatoid arthritis with rheumatoid factor of multiple sites w/o organ or systems involvement				
<input type="checkbox"/> M05.89—Other rheumatoid arthritis with rheumatoid factor of multiple sites				
<input type="checkbox"/> M06.09—Rheumatoid arthritis w/o rheumatoid factor, multiple sites				
<input type="checkbox"/> M06.89—Other specified rheumatoid arthritis, multiple sites				
<input type="checkbox"/> Other Diagnosis:			ICD-10 Code (Required):	
Special Instructions:				
Physicians Signature:			Date: <i>(Order is Valid for One Year)</i>	
REQUIRED DOCUMENTATION				
Please fax the following documents and records:				
● Patient Demographics		● Copy of the patient's insurance card(s) – front and back		
● Two most recent office notes (Supporting the DX and treatment ordered)		● Medication History		
● Most recent labs that include values for:		● For continuation of treatment, include the last infusion note		
● CMP, CBC, HBV Surface Antigen				
● TB Screening (PPD, QFT Gold or Tspot) or recent chest x-ray				
<i>We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.</i>				