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 Wheaton, MD 20902	☐ 14995 Shady Grove Road | Suite 250 Rockville, MD 20850	☐ 5454 Wisconsin Avenue | Suite 600 Chevy Chase, MD 20815
☐ 18111 Prince Philip Drive | Suite 323 Olney, MD 20832	☐ 161 Thomas Johnson Drive | Suite 250 Frederick, MD 21702	☐ 2021 K Street, NW | Suite 300 Washington, DC 20006
	☐ 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

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

Dosing/Frequency:

Preferred Product: ☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis

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

☐ Maintenance Dose: _____ mg/kg IV every _____ weeks ☐ Standard (150minutes) ☐ Accelerated (90minutes)

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.