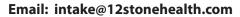
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





	INFLIXIMAB O	RDER FORM	И	
Date:	ICD-10 Code:			
Patient Name:	Allergies:		☐ New Start	
Date of Birth:			☐ Continuing Therap Last D	y: ose:
PROVIDER INFORMATION				
Ordering Provider: Provider Fax:				
	Provider Address:			
Provider Phone:				
MEDICATION ORDER				
Please Specify Desired Agent:  Infliximab  Therapeutic Interchange to insurance preferred product authorized unless otherwise specified below:  □ Initiation: Administer mg/kg IV over at I hours at weeks 0, 2, and 6 per protocol □ Maintenance: Administer mg/kg IV over at I hours every weeks per protocol □ If patient tolerates at least four infusion over two hours, a shortened infusion ra hour may be utilized.		least two least two ol.	lls for one year from of signature unless indicated belowRefills	Please include the following lab results required for infusion If no results are available, the following labs will be drawn prior to first infusion:  ✓ Negative TB Quantiferon Gold or TB Skin Test within the last 12 months  ✓ Hepatitis B Surface Antigen
	PRE-MEDI	CATIONS		
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:		IV       □ Dexamethasone:4mg8mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Methylprednisolone: 125mg         □ Hydrocortisone: 100mg         □ Ondansetron:4mg8mg         □ Other:		
LAB ORDERS (please indicate any labs to be drawn and frequency)		OTHER REQUIRED DOCUMENTATION		
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**  By signing below, I certify that the above therapy is med  By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as m  to payors with respect to this patient and prescription order. This enrollmer  Dispense as Written:		(Please fax this signed order form, along with the following documents to 800-223-4063)  • History & Physical, Last Office Visit Note  • Patient Demographics and Insurance Information  • Medication List  • Recent Lab Work  lically necessary. Prescriber's Signature (SIGN BELOW)  y designated agent in submitting prior authorizations and other clinically required information		
Prescriber Name	 Date	Prescriber Nan	ne	 Date