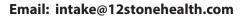
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





	INFLIXIMAB O	RDER FORM	И		
Date:	ICD-10 Code:	ICD-10 Code:		Therapy Status	
Patient Name:	Allergies:		☐ New Start		
	Weight:Ibs OR		☐ Continuing Therap Last D	y: ose:	
	PROVIDER IN	FORMATION			
Ordering Provider:		Provider Fax:			
	Provider Address:				
	MEDICATIO	N ORDER			
Please Specify Desired Agent:  Infliximab  Therapeutic Interchange to insurance preferred product authorized unless otherwise specified below:  ☐ Initiation: Administer mg/kg IV over at hours at weeks 0, 2, and 6 per protoco ☐ Maintenance: Administer mg/kg IV over at hours every weeks per protoco ☐ If patient tolerates at least four infusion over two hours, a shortened infusion rathour may be utilized.		least two least two ol.	lls for one year from of signature unless indicated below. Refills	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 a	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 enrollment		lically necessary. Prescriber's Signature (SIGN BELOW) by designated agent in submitting prior authorizations and other clinically required information			
Prescriber Signature	Date	Prescriber Sig	nature	 Date	