Allergy, Asthma & Immunology Center, P.C.
Infusion Services
www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

INFLECTRA® (INFLIXIMAB) ORDER FORM

(- Required Fields)*

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

Locations:

-------**Oklahoma**-------
___ Tulsa

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐ M ☐ F
ADDRESS:		PHONE:	
WEIGHT: ☐ LBS ☐ KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

INFLECTRA ORDER*:

ICD-10*: _____

*(SELECT **ONE** OF THE FOLLOWING)*

____ **Initial/Reloading Dosing and then Maintenance Dosing:**
_____mg/kg IV on day 0, 2, 6 weeks and every _____ weeks

OR

____ **Maintenance Dosing**: _____mg/kg IV every _____ weeks

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

_____ Ankylosing Spondylitis
_____ Crohn's Disease
_____ Psoriatic Arthritis
_____ Plaque Psoriasis
_____ Rheumatoid Arthritis
_____ Ulcerative Colitis
_____ Other_____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocols)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P
_____ HepB Core (If available)
_____ HepB Surf Ag (w/in 36 months)
_____ TB Results (w/in 6 months)-if positive, need negative chest Xray and negative TSpot

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

REVISION DATE- 5/2020