O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Infliximab/Biosimilar (Any infliximab product as required by the patients' health plan*)

*Infliximab products include: Remicade, Unbranded Infliximab, Avsola, Inflectra, Renflexis

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:			Weight:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date:			Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:		Office Email:	
Prescribing Providers Name:		Provider NPI:	
Office Address:		City: State:	Zip:
Office Phone Number:		Office Fax Number:	

DIAGNOSIS AND ICD 10 CODE		REQUIRED DOCUMENTATION
☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90	☐ This signed order form by the provider
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90	☐ Patient demographics AND insurance information (copy of cards)
☐ Rheumatoid Arthritis	ICD 10 Code: M06.9	☐ Clinical/Progress notes
☐ Ankylosing Spondylitis	ICD 10 Code: M45.9	☐ Lab and Tests supporting primary diagnosis
☐ Psoriatic Arthritis	ICD 10 Code: L40.52	☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody
☐ Plague Psoriasis	ICD 10 Code: L40.0	☐ Hepatitis C Test Results
☐ Other: _____	ICD 10 Code: _____	☐ TB Test Results

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

PREMEDICATION ORDERS

☐ No premeds
☐ Acetaminophen (Tylenol) PO ☐ 500mg ☐ 1000mg
☐ Diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)
☐ Methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ 62.5mg
☐ Fexofenadine (Allegra) PO ☐ 180mg

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)

■ Provider will select product (chosen based on patient's insurance coverage and availability)

Dose IV	☐ _____ mg (all doses must be calculated in mg. Doses will be rounded to the nearest whole vial)
Frequency	☐ Induction: at weeks 0, 2, 6 **THEN** ☐ q6 weeks ☐ q8 weeks ☐ q_____ weeks *if outside of PI please provide a letter of medical necessity

**Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.*

LAB ORDERS

☐ CBC w/ diff ☐ CMP ☐ CRP ☐ ESR ☐ Vitamin D OH Total ☐ Hep B Surface Antigen ☐ Quantiferon TB Gold ☐ Other:
☐ w/ every infusion ☐ w/ every other infusion ☐ Other:

Provider Name (Print) **Provider Signature:** **Date:**

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.