MPP Infusion Centers

A Multispecialty Physician Partner Company

Fax To: (855) 891-2191
Email To: MPPReferral@mppinfusion.com
Have a Question? Call: (855) 478-1528

INFLECTRA® (INFLIXIMAB) ORDER FORM

REFERRAL STATUS

☐ New Referral ☐ Order Renewal ☐ Restart ☐ Medication/Order Change ☐ Benefits Verification Only
☐ D/C Infusion *(Medication(s) to D/C* _____*)*

LOCATION

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake
☐ Tyler

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: ☐ MALE ☐ FEMALE
ADDRESS:	PHONE #:	
WEIGHT: ☐ LBS ☐ KG HEIGHT:	EMAIL:	
ALLERGIES:		

Please check that the following are included	☐ Patient demographics and insurance attached	☐ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	☐ Current Medication List	☐ TB Results (w/in 6 months)-*if positive, need negative chest Xray and negative TSpot*
	☐ HepB Surf Ag (w/in 36 months) (For IBD diagnosis w/in 12 months)	☐ HepB Core Ab (w/in 36 months) (For IBD diagnosis w/in 12 months)

PHYSICIAN INFORMATION

Physician Name:	Email *(if you would like referral updates)*:
Practice Name:	Phone Number:
Office Contact:	Fax Number:

DIAGNOSIS

☐ Crohn's Disease	☐ Rheumatoid Arthritis	☐ Other:
☐ Ulcerative Colitis	☐ Ankylosing Spondylitis	
☐ Psoriatic Arthritis	☐ Plaque Psoriasis	

ICD-10 CODE: **Date of last infusion/injection:**

MEDICATION ORDERS

INFLECTRA ORDERS:

☐ Initial Dose:_____mg/kg IV on day 0, 2 weeks, and 6 weeks and then every ____ weeks

☐ Maintenance Dose:_____mg/kg IV every _____ weeks.

Notes/Comments

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

STANDING LAB ORDERS

☐ Labs to be Drawn by Infusion Center Frequency: _____ Every Infusion ☐ Other (*please specify*) _____

☐ CMP ☐ CBC ☐ CRP ☐ ESRP ☐ HFR ☐ UA