MPP INFUSION CENTERS
A MULTISPECIALTY PHYSICIAN COMPANY

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

INFLECTRA® (INFLIXIMAB) ORDER FORM

(- Required Fields)*

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

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 MPP policy and protocols

REQUIRED DIAGNOSIS:

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

REQUIRED DOCUMENTATION CHECKLIST:

☐ Patient Demographics
☐ Insurance Card/Information
☐ Clinical/Progress Notes supporting DX
☐ Current Medication List and H&P
☐ HepB Core (w/in 36 months)
☐ 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 ☐ CRP ☐ ESRP ☐ HFR ☐ UA

☐ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

--------Colorado--------
☐ Lakewood

---------Florida---------
☐ Fort Myers Coming Soon
☐ Jacksonville
☐ Kissimmee Coming Soon
☐ Port St. Lucie
☐ Winter Park

----------Texas----------
☐ Arlington
☐ Cedar Hill
☐ Dallas
☐ Denton
☐ Ft. Worth Coming Soon
☐ Irving
☐ Rockwall
☐ Southlake
☐ Lewisville
☐ Plano
☐ Tyler

REVISION DATE- 11/2019