BARNES HEALTHCARE SERVICES

Remicade and Biosimilars Order Form

Please fax all pages of completed form to our Intake team at 888.276.7948
Contact our Intake team 800.422.5059 ext.1480

1 Patient Information — Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ **Last name** _____ **MI** _____
Preferred patient first name _____ **Preferred patient last name** _____
Sex at birth: ☐ Male ☐ Female **Gender identity** _____ **Pronouns** _____
Last 4 of SSN _____ **Date of birth** _____/_____/_____
Street address _____ **Apt #** _____
City _____ **State** _____ **Zip** _____
Home phone _____ **Cell phone** _____ **Email address** _____
Parent/guardian (if applicable)
Home phone _____ **Cell phone** _____ **Email address** _____
Alternate caregiver/contact
Home phone _____ **Cell phone** _____ **Email address** _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other **If other, please specify** _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Barnes Healthcare Services about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information — All fields must be completed to expedite prescription fulfillment.

Date _____ **Time** _____ **Date medication needed** _____/_____/_____
Office/clinic/institution name
Prescriber's first name _____ **Last name** _____
Prescriber's title _____ **If NP or PA, under direction of Dr.** _____
Office phone _____ **Fax** _____ **NPI #** _____ **License #** _____
Office contact and title _____ **Office contact email** _____
Office street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site

If infusion site, complete information below:

Infusion site name _____ **Clinic/hospital affiliation** _____
Site street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion site contact _____ **Phone** _____ **Fax**
Email _____

Note: Check the appropriate shipment options in Section 4: Prescribing Information.

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3 Clinical Information

Primary ICD-10 code (REQUIRED):_____

Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No

Please list all therapies tried/failed: _____

Patient wt _____ **Date wt obtained:** _____/_____/_____

☐ NKDA **Known drug allergies** _____

Concurrent meds: _____

4 Prescribing Information

Medication	Directions	Quantity/Refills
☐ Remicade®(infliximab) Inflectra®(infliximab-dyyb) Renflexis®(infliximab-abda) Avsola®(infliximab-axxq)	**Loading dose**: 5mg/kg mg IV at week: 0, 2, 6 3mg/kg mg IV at week: 0, 2, 6 Other **Maintenance dose**: (mg/kg) mg IV every we eks	**Loading dose:** 3 doses. No refills. **Maintenance dose:** 8-week supply. Refill x 1 year unless noted otherwise. week supply Refill x 1 year unless noted otherwise. Other

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
(S9359, S9379)

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE	

Date _____ ☐ **Dispense as written** **Date** _____ ☐ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.