



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.

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

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