Remicade

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.
Most Recent Demographics, Insurance Info, Current CBC & CMP, Recent H&P Relevant to Diagnosis
Current Meds, Recent TB & Hep B Results, Colonoscopy/Pathology (GI Only)

☐ Tried and failed medications: _____

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: ☐ **STAT Order**! ☐ Crohn's DZ-K50.9
☐ Ankylosing Spondylitis in Adults-M45 ☐ RA-M06.9
☐ Psoriatic Arthritis in Adults-L40.52
☐ Plaque Psoriasis-L40.0 ☐ Ulcerative Colitis-K51.9
☐ Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Verbal Order: **Clinician Name:**

Signature:

REMICADE DOSING:

☐ **3 mg/kg**
☐ **5 mg/kg**
☐ **7.5 mg/kg**
☐ **10 mg/kg**
OR ☐ **Total dose = _____mg**

☐ Round to the nearest vial (100mg per vial)

Route: IV

Remicade/Infliximab ONLY:
☐ Rapid infusion over one hour after first maintenance infusion

Frequency: ☐ Initial dose at 0, 2, 6 weeks, then Q8 weeks
Maintenance Only ☐ Q8 weeks
Other: _____

Date of Last Treatment, If Continuation: _____

Next Dose Due: _____

Additional Medications: ☐ Any history of adverse reactions

☐ Diphenhydramine	○ 25mg	○ 50mg	☐ PO	☐ IV	☐ Other _____	☐ N/A
☐ Acetaminophen	○ 325mg	○ 500mg	○ 650mg	PO	☐ Other _____	☐ N/A

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.