Remicade

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, Recent TB & Hep B Results, List of Tried & Failed Medications

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal ☐ Home Infusion

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ **STAT Order!** ☐ K50.___ ☐ K51.___ ☐ M06.00 ☐ M05.60 ☐ M05.70 ☐ M45.9 ☐ L40.50 ☐ L40.0 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

- ☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☑ TB Results (list results/date & attach clinicals):
  _____
- ☑ Hepatitis B Status & Date (list results & attach clinicals):
  _____
- ☑ List of Tried and Failed Medications:
  _____

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO
- ☐ Other: _____

  Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other: _____ ☐ Frequency: _____
- ☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- ☑ Remicade Intravenous Infusion

  Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg
  ☐ Total dose = _____ mg
  ☐ Round UP to the nearest vial (100mg per vial)

- ☐ Rapid infusion over one hour after first maintenance infusion

Frequency:
- ☐ Initial dose: 0, 2, 6 weeks, then Q8 weeks
- ☐ Maintenance: every 8 weeks
- ☐ Other: _____

- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
  (if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) | Provider Signature | Date

☐ ***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.***