REMICADE (infliximab) ORDERS

Please complete ALL fields and fax to 817-553-1393. An incomplete form will delay the processing/scheduling of the patient. Thank you for your referral and allowing us to partner with you in the care of your patient. Please call 817-553-1325 with any questions.

Patient Name: _____DOB: _____
Phone: _____Allergies: _____
Weight: _____ ❑ lbs/❑ kg

Primary Diagnosis: _____ ICD-10 Code: _____

Please send all of the following items to complete your referral to 817-553-1393:

- ❑ This completed order form
- ❑ Patient demographics and insurance information
- ❑ List of tried and failed medications for this diagnosis along with dates taken and reason for failure or intolerance
- ❑ Any other relevant lab work, office notes, scans or test results
- ❑ Most recent negative TB test (PPD skin test or TB Gold blood test). Must be within the last year.

Prescription: (*ORDER EXPIRES IN ONE YEAR)

- Start Peripheral IV Saline lock.
- Flush IV line with 3 to 10ml 0.9% Sodium Chloride before and after IV medication administration.

Pre-medications:

- ❑ Tylenol 1000 mg PO
- ❑ Benadryl 25 mg PO
- ❑ Decadron _____ mg IV
- ❑ Other: _____

- ❑ **REMICADE INDUCTION**- Infuse REMICADE _____MG/KG IV. INFUSE AT WEEK 0, 2, 6. THEN EVERY 8 WEEKS THEREAFTER.

- ❑ **REMICADE** _____MG/KG IV every _____ weeks. (order expires in one year)

- ❑ Other orders: _____
  _____

Ordering Provider Information

Name _____
Address _____
_____
NPI # _____
Signed _____

Office Contact Information

Name _____
Phone ( ) _____-_____
Fax ( ) _____-_____
Email _____
Date _____ /_____ /_____