*Princeton / Somerset New Jersey*
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

*Long Branch*
422 Morris Avenue
Suite 7
Long branch, NJ 07740

*Marlton*
127 Church Road
Suite 600
Marlton, NJ 08053

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

(infliximab)
# REMICADE infusion orders

Date: _____

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name: | DOB: | SEX: M ☐ F ☐ |
| ICD-10 code (required): | ICD-10 description: | |
| ☐NKDA Allergies: | | Weight lbs/kg: |

## REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| Referral Coordinator Name: | Referral Coordinator Email: | |
| Ordering Provider: | Provider NPI: | |
| Referring Practice Name: | Phone: | Fax: |
| Practice Address: | City: State: | Zip Code: |

### DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis
- ☐ _____ Psoriatic Arthritis 6 yro (PJIA)
- ☐ _____ Plaque Psoriasis
- ☐ _____ Ankylosing Spondylitis
- ☐ _____ Crohn's Disease
- ☐ _____ Ulcerative Coliti
- ☐ _____ _____ *(other)*

### PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

### REMICADE ORDERS

**PATIENT WEIGHT**

_____ lbs.

_____ kg

**DOSAGE**:

- ☐ _____ mg/kg / IV ***weight - based***
- ☐ _____ mg ***flat dosed***

**Frequency:**

- ☐ Every, 0,2,6, and every 8 weeks ***(induction)***
- ☐ Every _____ weeks
- ☐ Quant_____
- ☐ Total dosage ☐/refills_____

### NOTES/ADDITIONAL COMMENTS:

## ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____