☐ *Borough Park* 1428 36th Street Suite 107 Brooklyn, NY 11218
☐ *Crown Heights* 555 Lefferts Avenue Brooklyn, NY 11225
☐ *Manhattan* 57W 57Street Suite 601 New York, NY 10019
☐ *Manhasset* 333 East Shore Road Suite 201 Manhasset, NY 11030
☐ *Rockville Centre* 165 North Village Avenue Suite 133 Rockville Center, NY 11570
☐ *Elmsford/ Terrytown* 555 Taxter Road 3rd Floor Elmsford, NY 10523
☐ *NYC Central Park West* 115 Central Park West Suite 15 New York, NY 10023
☐ *Woodbury* 75 Froehlich Farm Woodbury, NY 11797
☐ *Staten Island* 27 New Dorp Lane Staten Island, NY 10306

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

☐ *Manhattan* 225 E 70th Street Suite 1E New York, NY 10021
☐ *Queens* 64-05 Yellowstone Blvd CF104 Forest Hills, NY 11375
☐ *Manhattan* 225 East 70th Street New York, NY 10021
☐ *Holbrook/ Ronkonkoma* 233 Union Ave Suite 207 Holbrook, NY 11741
☐ *Scarsdale* 495 Central Park Avenue Suite 205 Scarsdale, NY 10583
☐ *5 Towns* 141 Washington Avenue Cedarhurst, NY 11559
☐ *Long Beach* 917 Beech Street Long Beach, NY 11561
☐ *Riverhead* 1228 E Main Street Suite A Riverhead, NY 11901
☐ *Bronx* 226 West 238th Street Bronx, NY 10463

(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 ____________