Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

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

Mission Medical

(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 _____