

Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081



Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

(infliximab)

REMICADE

Date: _____

infusion orders

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 (PJA)
☐ _____ Plaque Psoriasis
☐ _____ Ankylosing Spondylitis
☐ _____ Crohn's Disease
☐ _____ Ulcerative Coliti
☐ _____ (other)

PRE-MEDICATION

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