

TN
100 Covey Drive
Suite 307
Franklin, TN 37067

(influximab)
REMICADE infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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 _____