

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex: M / F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs / kg  
 Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Patient Preferred Location: \_\_\_\_\_

**<ICD 10 CODE REQUIRED>**
**DIAGNOSIS & CLINICAL INFORMATION**
**ICD 10 Code (PROVIDE COMPLETE CODE)**
**DERMATOLOGY**

- L40.5 \_\_\_\_\_ Psoriatic Arthritis/Arthropathy  
 L40. \_\_\_\_\_ Psoriasis

**GASTROENTEROLOGY**

- K50.0 \_\_\_\_\_ Crohn's Disease, Small Intestine  
 K50.1 \_\_\_\_\_ Crohn's Disease, Large Intestine

- K50.8 \_\_\_\_\_ Crohn's Disease, Small & Large Intestine  
 K50.9 \_\_\_\_\_ Crohn's Disease, Unspecified  
 K51.8 \_\_\_\_\_ Other Ulcerative Colitis, Chronic  
 K51.5 \_\_\_\_\_ Left Sided - Ulcerative Colitis, Chronic  
 K51.0 \_\_\_\_\_ Universal Ulcerative Pancolitis, Chronic  
 K51.9 \_\_\_\_\_ Ulcerative Colitis, Unspecified  
 K60.3 Anal Fistula  
 K63.2 Fistula of Intestine

**RHEUMATOLOGY**

- M05. \_\_\_\_\_ Rheumatoid Arthritis, w/ Rheumatoid Factor  
 M06. \_\_\_\_\_ Rheumatoid Arthritis, w/o Rheumatoid Factor  
 L40.5 \_\_\_\_\_ Psoriatic Arthritis/Arthropathy  
 M45. \_\_\_\_\_ Ankylosing Spondylitis  
 D86.0 Sarcoidosis of the Lung

**OTHER:** \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**  
**LAB RESULTS: Include Negative Hepatitis B within 3 years and Negative TB within 12 months.**

**PRESCRIPTION**
**Pre-Medications**

- Acetaminophen: 650 mg PO  
 Cetirizine: 10 mg PO  
 Diphenhydramine: 25 mg PO  
 Diphenhydramine: 25 mg IVP  
 Famotidine: 20 mg PO  
 Methylprednisolone: 125 mg SIVP  
 Other: \_\_\_\_\_

**Lab Orders+**
*Required:* Negative TB, annually

**+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.**
**Remicade (infliximab)**

Infuse in 250 mL of 0.9% NS over at least 2 hours via pump with 0.2-micron filter. Doses &gt; 1000 mg need total volume of 500 mL. Medix Infusion offers Remicade at a reduced infusion time, beginning on the 4th and subsequent infusions, to patients who qualify and consent.

**Loading Dose: (SELECT ONE)**

- IV: Infuse 3 mg/kg at weeks 0, 2, and 6  
 IV: Infuse 5 mg/kg at weeks 0, 2, and 6  
 IV: Infuse \_\_\_\_\_ mg or \_\_\_\_\_ mg/kg at weeks 0, 2, and 6

**Maintenance: (SELECT ONE)**

- IV: Infuse 3 mg/kg every 8 weeks for one year  
 IV: Infuse 5 mg/kg every 8 weeks for one year  
 IV: Infuse \_\_\_\_\_ mg or \_\_\_\_\_ mg/kg every \_\_\_\_\_ weeks for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

**Post Treatment Observations:** The patient is observed for 30 minutes following the first infusion.

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ **Signature:** \_\_\_\_\_  
 Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Supervising Physician: \_\_\_\_\_ (If Applicable)  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_