Remicade Order Form
(infliximab)

FAX TO: 972.499.9210

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

☐ 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 & 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 > 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 Dose (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 week for one year

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.
Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.
Comments:

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____