

## 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.**

**RENFLEXIS (infliximab-abda)**

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: \_\_\_\_\_