

Patient Information

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

Diagnosis

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

Other ICD 10 Code: _____
 Description: _____

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: _____

Medication Order

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

Requested Add'l Lab Orders:

Loading Dose (SELECT ONE)

IV: Infuse 3 mg/kg at weeks 0, 2, and 6 then every 8 weeks x 1 year
 IV: Infuse 5 mg/kg at weeks 0, 2, and 6 then every 8 weeks x 1 year
 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 _____ weeks for one year

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

ACCELERATED INFUSION: After 4 consecutive lifetime doses without adverse reactions, administration time may be reduced to the protocol: Decline accelerated rate. Yes No

Comments: _____

Required Clinical Documentation

REQUIRED: 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.

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

LAB RESULTS: Include Negative Hepatitis B within 3 years and Negative TB within 12 months. Medix Infusion will collect all necessary labs if not included in referral documents.

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Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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