PURE INFUSION SUITES

INFUSION ORDERS REMICADE (infliximab)

Fax form to:

CO - Colorado Springs - 1.719.623.0085
CO - Grand Junction - 1.970.404.8100
CO - Lone Tree - 1.720.246.2925
FL - Bonita Springs - 1.239.237.5547
FL - Jacksonville - 1.904.830.0718
ID - Boise - 1.208.545.3214
ID - Twin Falls - 1.208.487.7679
MT - Billings - 1.406.206.0105
MT - Great Falls - 1.406.794.0555
UT - Salt Lake City - 1.801.852.0999

Note: you must enter a 1 before the fax number

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

***Please fax all recent labs including TB date/results and Hepatitis B date/results.**

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval**

REMICADE DOSING

- ☐ 5 H P L F D ☒ H ☒ R ☒ H R I P ☒ N ☒
- ☐ 5 H P L F D ☒ H ☒ R ☒ H R I P ☒ N ☒
- ☐ 5 H P L F D ☒ H ☒ R ☒ H R I P ☒ N
- ☐ 5 H P L F D ☒ H ☒ R ☒ H

Refills:

Frequency

- ☐ Loading dose of day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter
- ☐ Specific dosing frequency of

Premedications

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

☐ ☐ U F ☐ ☐ N F

Provider Phone | Provider Fax