

INFUSION ORDERS REMICADE (infliximab)

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

Remicade dose of 3mg/kg IV

Remicade dose of 5mg/kg IV

Remicade dose of 10mg/kg IV

Remicade specific dose of

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

Date/Time

Provider Phone

Provider Fax