

**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**

**FOLLOWS REMICADE DOSING**

Renflexis dose of 3mg/kg IV

Renflexis dose of 5mg/kg IV

Renflexis dose of 10mg/kg IV

Renflexis 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

Provider Phone

Provider Fax