Local Infusion

MYLOCALINFUSION.COM

REMICADE (INFLIXIMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

❑ Rheumatoid Arthritis, ICD 10: M05._____ or M06._____

❑ Plaque Psoriasis, ICD 10: L40.0

❑ Psoriatic Arthritis, ICD 10: L40._____

❑ Other: _____

❑ Ankylosing Spondylitis, ICD 10: M45._____

❑ Crohn's Disease, ICD 10: K50._____

❑ Ulcerative Colitis, ICD 10: K51._____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Remicade	❑ _____ mg/kg ❑ _____ mg	❑ IV	❑ Weeks 0, 2, 6 and then every 8 weeks ❑ Every 8 weeks ❑ Every ____ weeks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371 ❒ NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: _____