REMICADE(infliximab)

◉ New Prescription/Referral
○ Prescription Refill

# of Refills:

Rx:

Patient Name: | **Patient Weight:** kg | **DOB:**

REMICADE:

- ☐ Administer 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks via IV for > 2 hours with an in-line filter
- ☐ Administer 5mg/kg every 4 weeks via IV for > 2 hours with an in-line filter
- ☐ Administer 10mg/kg every 8 weeks via IV for > 2 hours with an in-line filter

Other Orders:

☐ OK to substitute with approved Biosimilars (Avsola, Renflexis, Infliximab, Inflectra, etc).
Please provide detailed order below.

Pre-Medication: (30 mins prior)

- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Others:

☐ Tylenol _____mg PO
☐ 650mg ☐ 975mg

☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO

ANA Kit Protocol:
☐ OK to use

Dx:

- ☐ Crohn's Disease (K50.90)
- ☐ Psoriatic Arthritis (L40.5)
- ☐ OTHERS:
- ☐ Ulcerative Colitis (K51.90)
- ☐ Rheumatoid Arthritis (M06.9)
- ☐ Ankylosing Spondylitis (M45)
- ☐ Plaque Psoriasis (L40.0)

Physician Signature | **N P I #:** | **Date: (Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: | **CLINIC:**

Contact Information: **Phone:** | **Email:**
Fax: | **Other:**

Office Mailing Address:

Please include the following

- ☐ Patient demographics
- ☐ Lab Results
- ☐ Insurance attached
- ☐ Clinical progress notes
- ☐ Diagnosis (supporting)
- ☐ Medication List
- ☐ History and Physical
- ☐ Other Test Results