

***Patient Insurance & ID (front and back) are needed**

REMICADE(infliximab)

New Prescription/Referral
Prescription Refill

of Refills:

Rx:

Patient Name:

Patient Weight:

DOB:

kg

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

NPI#:

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