NORTH TEXAS INFUSION CENTERS

Remicade® (infliximab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. TB screening and Hepatitis B vaccine or testing documentation

_____ _____
Patient Name **DOB**

_____ _____ _____ _____
Height **Weight** **Allergies** **Patient Phone**

Diagnosis (must include ICD-10 code)
☐ Rheumatoid Arthritis _____ ☐ Psoriatic Arthropathy _____
☐ Psoriasis _____ ☐ Ankylosing Spondylitis _____
☐ Crohn's Disease _____ ☐ Ulcerative Colitis _____
☐ Other (ICD-10 Code):_____

<u>Prescription Orders: Remicade® (infliximab)</u> (quantity: 100 mg per vial)

☐ Initial Dosing: _____ mg/kg IV on day 0, 2 weeks, 6 weeks, then every _____ weeks.
☐ Renewal Dosing:_____mg/kg IV every_____weeks. (date of last infusion_____)

Pre-Medications:
☐ Acetaminophen 650mg PO ☐ Benadryl 25 mg IVP ☐ Solu-Medrol 40mg IVP
☐ Benadryl 50 mg IVP ☐ Solu-Medrol 125 mg IVP
☐ Other _____

Standing Lab Orders: ☐ **CMP** ☐ **CBC** ☐ **ESR** ☐ **CRP** ☐ **Other:_____every infusion**
Refills: ☐ **12 months** ☐ **_____ infusions**

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436.Contact us directly at: (214) 276-5642.
Or visit us online at www.ntinfusioncenters.com

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