REMICADE(infliximab)

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills:

Rx:

Patient Name:

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)
☐ Ulcerative Colitis (K51.90)
☐ Ankylosing Spondylitis (M45)
☐ Psoriatic Arthritis (L40.5)
☐ Rheumatoid Arthritis (M06.9)
☐ Plaque Psoriasis (L40.0)
☐ OTHERS:

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:

Fax:

Email:

Other:

Office Mailing Address:

Please include the following

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