RESTORE HEALTH
INFUSION AND WELLNESS

REMICADE

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB Test

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER INFORMATION

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL INFORMATION

Diagnosis: ☐ K51.9 (Ulcerative Colitis) ☐ K50.9 (Crohn's Disease) ☐ L40.0 (Psoriasis Vulgaris)
☐ M06.00 (Rheumatoid Arthritis w/o RF) ☐ Other: _____

Allergies: _____ **Weight:** _____ ☐ Kg ☐ Lbs **Height:** _____ ☐ cm ☐ in

TB/PPD test: ☐ Positive ☐ Negative **HBV:** ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

TREATMENT INFORMATION

REMICADE (infliximab)

Route: Intravenous Infusion

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg
☐ 10mg/kg ☐ Other: ____ mg/kg

Frequency:

☐ Induction: On weeks 0, 2, and 6

☐ Maintenance: Once every ____
- ☐ 4 weeks
- ☐ 6 weeks
- ☐ 8 weeks
- ☐ Other: _____

Quantity: _____ **Refills:** ____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

Special Instructions: _____

_____

_____

_____

Provider Name: _____ **Provider Signature:** _____ **Date:** _____