REMICADE (INFLIXIMAB) Referral Order Form

WWW.PACEINFUSION.COM
PH:330-625-4900

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

PACE HEALTHCARE can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone #: _____ Contact Fax #: _____

NPI / TIN: _____ _____

REMICADE MEDICATION ORDERS

Patient Weight: _____ kg

☐ Initial/Reload Dosing: _____ mg/kg IV on day 0, 2 weeks, 6 weeks then every _____ 6 or 8 weeks.

☐ Maintenance Dosing: _____ mg/kg IV every _____ 6 or 8 weeks.

☐ 5mg/kg ☐ 3mg/kg ☐ other: _____

Premeds: ☐ Benadryl ☐ APAP ☐ Famotidine (IV) ☐ Hydrocortisone

indication/diagnosis

☐ K50.90 Crohn's disease, unspecified, without complications

☐ K51.90 Ulcerative colitis, unspecified, without complications

☐ M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement

☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites

☐ M06.9 Rheumatoid arthritis, unspecified

☐ Other *(please specify in notes)*

***icd-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____ _____

Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report (w/in past 6 months)

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS

☐ HepB Surf Ag (w/in 12 months) ☐ HepB Core Ab (w/in 12 months)

☐ Chest X-ray (if indicated) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

☐ TB test (w/in 12 months)

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY

02/2023