# REMICADE (INFLIXIMAB) Pediatric Referral Order Form

PACE HEALTHCARE LLC

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# _____

Parent / Caregiver: _____

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.

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

Infusion Rate: 15ml/hr x 15min , 30ml/hr x 15min , 60ml/hr x 30min , 90ml/hr to completion if tolerated. Infuse over at least 2 hours.

### INDICATION/DIAGNOSIS

☐ Crohn's Disease ☐ Ulcerative Colitis
☐ JIA ☐ Other *(please specify in notes)*

***ICD-10** _____ **required**

_____ _____
Referring Physician's Signature Date

### NOTES (ADDITIONAL INFO)

## 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 (FOR NEW REFERRALS ONLY)

☐ HepB Surf Ag (w/in 12 months) ☐ HepB Core Ab (w/in 12 months) ☐ PPD Results (w/in 12 months)
☐ Chest X-ray (if indicated) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

**APPOINTMENT DATE & TIME:** _____

***FOR OFFICE USE ONLY***