Remicade

(Or other Infliximab products such as Inflectra, Avsola, or Renflexis as required by the patients Health plan)

RHEUMATOLOGY CONSULTANTS of WNY

WNY Infusion Center

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, Recent TB & Hep B Results

Please check "X" if applicable

PATIENT INFORMATION

Referral Status: _____New Referral _____Updated Order _____Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): __K50.___ __K51.___ __M06.00 __M05.60 __M05.70 __M45.9 __L40.50 __L40.0
ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ____ New to therapy ____ Continuing Therapy Last Treatment Date: Next Due date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

→ TB Status and Date (list results & attached clinicals)

→ Hepatitis B Status & Date (list results & attached clinicals)

LABORATORY ORDERS

___ CBC ___ at each dose ___every _____

___ CMP ___ at each dose ___every _____

___Other_____ ___every_____

___ Please "X" if you DO NOT authorize RCWNY to order and draw labs indicated for clinical clearance and/or Insurance authorization prior to treatment

PRE-MEDICATION ORDERS

Pre-medications not usually indicated

- ☐ Diphenhydramine ___ 25mg / ___50mg ___PO/___IV
- ☐ Acetaminophen ___325mg / ___500mg / ___650mg PO
- ☐ Other _____

Dose:_____ Route: _____Frequency: _____

THERAPY ADMINISTRATION

-Infliximab Intravenous Infusion
Dose-Weight Based: __3mg/kg __5mg/kg
__7.5mg/kg __10mg/kg OR
__Total Dose = ___mg
Frequency: Induction: Week 0, 2, and 6
Maintenance: Every __4 weeks / __6 weeks / __8 weeks
Refills: ____Zero / ____for 12 months / ____ _____
(if not indicated order will expire one year from date signed)

Provider Name (Print)	Provider Signature	Date