REMICADE (INFLIXIMAB) Referral Order Form

FAX (877) 637-6691

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

Vasco Infusion 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

01/2019