

**Richmond**  
7110 Forest Ave, Suite 203  
Richmond, VA 23226



**Prince George**  
2025 Waterside Rd, Suite 100B  
Prince George, VA 23875

**Physician Order - Remicade (Infliximab)**

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose/Frequency Change
<input type="checkbox"/> Order Renewal	

Location Preference (optional)	
<input type="checkbox"/> Richmond	<input type="checkbox"/> Prince George

\*If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required\*

DIAGNOSIS AND ICD-10 CODE	
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	K51.90
<input type="checkbox"/> Moderate to Severe Crohn's Disease	K50.90
<input type="checkbox"/> Rheumatoid Arthritis	M06.9
<input type="checkbox"/> Ankylosing Spondylitis	M45.9
<input type="checkbox"/> Psoriatic Arthritis	L40.50
<input type="checkbox"/> Plaque Psoriasis	L40.0
<input type="checkbox"/> Other: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> Negative QuantiFERON Gold TB Test or Skin PPD	<input type="checkbox"/> HBV Panel results
<input type="checkbox"/> Patient currently receiving same therapy at _____	Last dose: _____
List Tried & Failed Therapies, including duration of treatment	
1) _____	3) _____
2) _____	4) _____

MEDICATION ORDERS**	
Initial Dosing	<input type="checkbox"/> Remicade 3mg/kg infuse IV over 2 hours at week 0, 2, 6, then every 8 weeks <input type="checkbox"/> Remicade 5mg/kg infuse IV over 2 hours at week 0, 2, 6, then every 8 weeks <input type="checkbox"/> Remicade ___ mg/kg infuse IV over 2 hours at week 0, 2, 6, then every 8 weeks
Maintenance Dosing	<input type="checkbox"/> Remicade 5mg/kg infuse IV over 2 hours every 8 weeks <input type="checkbox"/> Remicade 10mg/kg infuse IV over 2 hours every 8 weeks
Alternative Dosing	<input type="checkbox"/> Remicade __ mg/kg infuse IV over 2 hours every ___ weeks
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in
Duration: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____	

\*\*For all weight-based therapies, Infusion Solutions will obtain/verify a patient's current weight within one week of dosing.

OPTIONAL PREMEDICATIONS and LAB ORDERS	
<input type="checkbox"/> Acetaminophen 650mg PO prior to infusion	
<input type="checkbox"/> Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion	
<input type="checkbox"/> Methylprednisolone 40mg slow IVP prior to infusion	
<input type="checkbox"/> CMP drawn yearly	
<input type="checkbox"/> Other PreMed or Lab Order with frequency: _____	

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION			
Prescriber Name:	NPI:	Contact:	
Phone:	Fax:	Email:	
Prescriber Signature:			Date:

Contact us with questions at: 804-442-3558 or email [referrals@theinfusionsolution.com](mailto:referrals@theinfusionsolution.com)

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.