REMICADE (INFLIXIMAB)

FAX (877) 428-1627

WWW.CURBSIDEINFUSION.COM

PH: 877-428-7248 fax: 877-428-1627

☐ 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: ________________________ Date: ________

DOB: ________________ SS# ________________

Phone # ________________

Email: ________________________________

PHYSICIAN INFORMATION

Referring Physician: ________________________________

Practice Address: ________________________________

____

Office Contact: ________________________________

Contact Phone #: __________ Contact Fax #: __________

NPI / DEA#: ________________ ________________

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: ________ Refills: ____________

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

INDICATION/DIAGNOSIS

☐ Crohn's Disease
☐ Rheumatoid Arthritis
☐ Psoriatic Arthritis
☐ Plaque Psoriasis
☐ Ankylosing Spondylitis
☐ Ulcerative Colitis
☐ 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 6 months) ☐ HepB Core Ab (w/in 6 months) ☐ PPD Results (w/in 12 months) ☐ Rheumatoid Factor

☐ 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