

WWW.CURBSIDEINFUSION.COM

Phone: 281-406-1046 Fax: 281-406-1047

| New Referral Restart Medication/ Order Change Benefits Verification D/C Infusions (New Order Required) Only | |
|---|--|
| Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners. | |
| PATIENT INFORMATION | PHYSICIAN INFORMATION |
| Name: Date: | Referring Physician: |
| DOB: SS# | Practice Address: |
| Phone # | Office Contact: |
| Email: | Contact Phone #: Contact Fax #: |
| | NPI / DEA#: |
| REMICADE MEDICATION ORDERS | |
| ☐ Maintenance Dosing: | _mg/kg IV on day 0, 2 weeks, 6 weeks then every 6 or 8 weeksmg/kg IV every 6 or 8 weeks5mg/kg □3mg/kg □other: Refills: |
| Premeds: ☐Benadryl ☐ APAP ☐ Famotidine (IV) ☐ Hydrocortisone Quzyttir 10mg IVSP over 1-2 min | |
| INDICATION/DIAGNOSIS Crohn's Disease Ankylosing Spondylitis Ulcerative Colitis Psoriatic Arthritis Plaque Psoriasis NOTES (ADDITIONAL INFO) NOTES (ADDITIONAL INFO) | |
| *ICD-10required | |
| | |
| Referring Physician's Signature Date | |
| REQUIRED DOCUMENTATION | |
| ☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report ☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet (w/in past 6 months) | |
| 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: | |