

Patient Information

Patient Name:		DOB:	
Patient Phone:		Patient Email:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
			Last infusion date (if applicable): _____
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
		Does the patient need interpreter services: Yes No	

Provider Information

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip:

ICD-10 CODE

K50.90 Crohn's/Pediatric Crohn's Disease	L40.50 Psoriatic Arthritis
K51.90 Ulcerative Colitis/Pediatric UC	L40.0 Plaque Psoriasis
M06.9 Rheumatoid arthritis	Other: _____
M45.9 Ankylosing Spondylitis	

Medication Order

Remicade (infliximab)	Preferred Agent (only select one)	Use if preferred agent is not covered by the patients insurance
Avsola (infliximab-axxq)	Preferred Agent (only select one)	Use if preferred agent is not covered by the patients insurance
Renflexis (infliximab-abda)	Preferred Agent (only select one)	Use if preferred agent is not covered by the patients insurance

Dose: 3mg/kg IV Other: _____ 5mg/kg IV Round up to nearest 100mg from dosage indicated above 7.5mg/kg IV Give exact dose selected above 10mg/kg IV	Frequency: Initiation therapy: 0, 2 and 6 weeks then every 8 weeks Initiation therapy: 0, 2 and 6 weeks then every 6 weeks Initiation therapy: 0, 2 and 6 weeks then every _____ weeks Maintenance therapy: Every 8 weeks Maintenance therapy: Every 6 weeks Maintenance therapy: Every _____ weeks
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Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (Negative Hep B and TB)	Insurance Card (front and back)	Current Medications	History/Progress Notes
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Pre-Medication Orders

acetaminophen (Tylenol) 500mg 650mg 1000mg PO	diphenhydramine (Benadryl) 25mg 50mg / PO IV
cetirizine (Zyrtec) 10mg PO	methylprednisolone (Solu-Medrol) 40mg IV 125mg IV
loratadine (Claritin) 10mg PO	hydrocortisone (Solu-Cortef) 100mg IV

Other: _____

Dose: _____ Route: _____ Frequency: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name	Provider Signature	Date
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Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order

Patient Information

Patient Name:	DOB:	Sex:	M	F
Patient Phone:	Fasting:	Y	N	

Lab Test (Please circle or write in ICD-10)

ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	HIV VIRAL LOAD	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20
AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE	J45.4, J45.3, L50.9, J45.40, J45.50
HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG	G35, G36.0
BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
CALCIUM	M81.0, M81.8	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
CREATININE	M81.0, M81.8, G35	PSA	R97.20, C61, N40.1, Z12.5, N40.0
C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
G6PD	M1A.9XX0, M1A.9XX1	QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
GROWTH HORMONE	E22, C7A.1, E34	TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
HBSAG CONFIRMATION	Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)	
HIV 4TH GEN	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20		
HIV 1/2 AB DIFF	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20		

Frequency

Prior to each dose Yearly Other: Please Specify Below

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Provider Name _____ Provider Signature _____ Date _____

Provider Phone _____