

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ lbs kg

Allergies: _____ NKDA

Patient status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

Rheumatoid Arthritis M06.9 Crohn's Disease K50. _____ Psoriasis L40. _____

Ankylosing Spondylitis M45. _____ Ulcerative Colitis K51. _____ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

Acetaminophen (Tylenol) PO 500 mg 650 mg 1000 mg
 Diphenhydramine (Benadryl) PO IV 25 mg 50 mg
 Methylprednisolone (Solu-Medrol) IV 40 mg 125 mg
 Cetirizine (Zyrtec) 10 mg PO
 Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
<input type="checkbox"/> Remicade (Infliximab), IV Mix in 250ml 0.9% sodium chloride, (use in line filter 1.2 micron or less)	<input type="checkbox"/> 3 mg/kg <input type="checkbox"/> 5 mg/kg <input type="checkbox"/> 10 mg/kg	<input type="checkbox"/> week 0, 2, 6 and then every 8 weeks <input type="checkbox"/> every 8 weeks
<input type="checkbox"/> Infliximab Biosimilar: <input type="checkbox"/> Inflectra <input type="checkbox"/> Avsola <input type="checkbox"/> Renflexis	Other Dose: _____	

Refills Zero 12 months _____ Order valid for 1 year unless otherwise stated. _____

- Infuse over 2 hours.
- Flush with 0.9% sodium chloride at infusion completion.
- Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
 Other at each dose every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

- Patient Demographics Insurance card Progress Notes supporting DX TB status results Hepatitis B status results

Provider Signature _____ Date _____