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INFLIXIMAB TREATMENT REQUEST

Patient:___________________________Phone:__________________Date:___________
SSN:____________________DOB:_________Requested Infusion site_______________
Insurance Carrier___________________ Policy Number__________________________

Prescription

Remicade contraindications: Mouse allergy, CHF, current/active infections

Patient Wt:__________kg Allergies:____________________________

- TB Test Yes ______ No________ N/A______________
- If treated for TB, last Chest x-ray and results______________________________
- Infliximab Order 5mg/kg IV_______3mg/kg IV________10mg/kg IV_________

  Induction 0, 2 & 6 weeks__________ Maintenance every 8 weeks____________
- Pre-meds (Choose H1 and H2)

  Zyrtec 10 mg PO _____ or Claritin 10 mg PO _____
  &
  Zantac 150 mg PO ____ or Pepcid 40 mg PO ______
- Tylenol 1000mg (at time of infusion) _______
- Other medications:

  Solu-medrol 60mg IV prior to infusion_____Predisone 40/40/40_____
  Other______________________________________

  See standing orders for special meds.

Statement of Medical Necessity

- Primary Diagnosis
  ___555.0 Crohn's Disease (small intestine) ___555.1 Crohn's (large intestine)
  ___555.2 Crohn's (small & large intestine) ___555.9 Crohn's (unspecific)
  ___556.6 Ulcerative Colitis ___714.0 Rheumatoid Arthritis
  ___696.1 Psoriasis
- Disease Severity __ Mild___Moderate ___Severe ___Fistulas
- Pertinent Medical History:____
  ____

Physician's Signature_____________________________________ Date:_____________
Physician's Printed Name__________________________________