RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Inflectra Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Inflectra Medication Orders

Dosage

- _____ 5mg/kg IV at 0,2, and 6 weeks, then every 8 weeks
- _____ 5mg/kg IV at 0,2, and 6 weeks, then every 6 weeks
- _____ Other _____
- _____ 3mg/kg IV at 0,2, and 6 weeks, then every 8 weeks
- _____ 10mg/kg IV every 8 weeks

Patient Weight: _____ Lbs or _____ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: _____ Crohn's Disease ____ Rheumatoid Arthritis ____ Psoriatic Arthritis ___Ankylosing Spondylitis ____ Ulcerative Colitis ____ Plaque Psoriasis
- ICD 10 code _____

Pre-Medication	Refills
• Tylenol _____mg • Benadryl _____ mg __IV or ___PO • Solumedrol IV Push _____ mg • Other _____	• Zero _____ • Treatments for 1 year _____ • Other _____

Required Documentation

○ **Insurance Cards (Front and Back)**	○ **Patient Demographics**	○ **Recent Progress Notes**
	○ **Lab Results – CMP, CBC, TB and Hep B screening**	

Special Instructions/Notes

_____ _____

Prescribing Provider Signature **Date of Signature**