

RECOVERY ROOM IV THERAPY, LLP.

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

Remicade 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:

Remicade Medication Orders

Dosage	
<ul style="list-style-type: none">• _____ 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 _____	<ul style="list-style-type: none">• _____ 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)	
<ul style="list-style-type: none">• Diagnosis: _____ Crohn's Disease _____ Rheumatoid Arthritis _____ Psoriatic Arthritis _____ Ankylosing Spondylitis _____ Ulcerative Colitis _____ Plaque Psoriasis• ICD 10 code _____	
Pre-Medication	Refills
<ul style="list-style-type: none">• Tylenol _____ mg• Benadryl _____ mg __ IV or __ PO• Solumedrol IV Push _____ mg• Other _____	<ul style="list-style-type: none">• Zero _____• Treatments for 1 year _____• Other _____

Required Documentation

<input type="checkbox"/> Insurance Cards (Front and Back)	<input type="checkbox"/> Patient Demographics	<input type="checkbox"/> Recent Progress Notes
<input type="checkbox"/> Lab Results – CMP, CBC, TB and Hep B screening		
Special Instructions/Notes		

Prescribing Provider Signature

Date of Signature