Infliximab (Remicade®) Order Form **FAX to 1 (888) 797-4008**

PATIENT INFORMATION		
Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is patient a Wayne Health patient registered in athena? ☐ Yes ☐ No		
Order date:	Weight: kg	Height: m
Drug allergies: ☐ NKDA. ☐ YES. Please specify.		
ICD-10 diagnosis:		

LABORATORY DATA		
CBC:	BMP:	Serology:
Other:		

TB Screening
TST (PPD): ☐ Not done ☐ 5-9 mm ☐ 10-14 mm ☐ ≥ 15 mm Date of test:
IGRA: ☐ Not done ☐ Positive ☐ Negative ☐ Indeterminate/Borderline Date of test:

Infliximab (Remicade®)				
Dose		**Directions**		**Refills**
☐ 3 mg/kg	☐ 10 mg/kg	☐ q 2 wks	☐ q 8 wks	
☐ 5 mg/kg	☐ Other:	☐ q 6 wks	☐ Other:	

ORDERING PHYSICIAN INFORMATION	
Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.