Hunt Regional Infusion Centers

REMICADE ORDER FORM

Phone: 903–408–5840
Fax: 903–455–8773

PATIENT INFORMATION

Date:_____

Last Name:_____ First Name:_____ MI:_____

HT:_____ WT:_____ DOB:_____ Sex: ( ) Male ( ) Female SSN:_____

Street Address:_____ City/State/Zip:_____

Home Phone #:_____ Work #:_____ Cell #:_____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name:_____ Insurance Phone #:_____

Group/Policy Number:_____ Employer:_____

Cardholder Name & SSN:_____

Secondary Insurance Name:_____ Insurance Phone #:_____

Group/Policy Number:_____ Employer:_____

Cardholder Name & SSN:_____

PHYSICIAN / FACILITY INFORMATION

Physician's Name:_____ Contact Name:_____ Contact Phone #:_____

Street Address:_____ City/State/Zip:_____

DEA#:_____ Phone #:_____ Fax #:_____

STATEMENT OF MEDICAL NECESSITY

- ❑ **K50.00** Crohn's disease of small intestine w/o complications
- ❑ **K50.10** Crohn's disease of large intestine w/o complicatons
- ❑ **K50.80** Crohn's disease of both small and large intestine w/o complications
- ❑ **K51.00** Ulcerative pancolitis w/o complications
- ❑ **K51.80** Other ulceratvie colitis w/o complications
- ❑ **K51.20** Ulcerative proctitis w/o complications
- ❑ **K51.30** Ulcerative rectosigmoiditis w/o complications
- ❑ **K51.80** Other ulceratvie colitis w/o complications

Primary Diagnosis: (ICD–10 Code plus Description)

- ❑ **K51.50** Left sided colitis w/o complications
- ❑ **K60.3** Anal fistula
- ❑ **K63.2** Fisutla of intestine
- ❑ **M06.9** Rheumatoid arthritis,unsp
- ❑ **M05.60** RA of unsp site w/involvement of other organs and systems
- ❑ **L40.50** Arthropathic psoriasis,unsp
- ❑ **M45.9** Ankylosing spondylitis of unsp sites in spine

PERTINENT MEDICAL HISTORY

TB test performed? ○ Yes ○ No Results _____ Patient diagnosed with Congestive Heart Failure? ○ Yes ○ No

Liver function test normal? ○ Yes ○ No Does the patient have venous access? ○ Yes ○ No If Yes, what type? _____

Labs needed? _____

Patient previously treated with Remicade? ○ Yes ○ No Date: _____

Patient had Hep–B antigen surface antibody test? ○ Yes ○ No Date: _____

PRESCRIPTION ORDERS RX: REMICADE® (INFLIXIMAB)

Qty: _____ 100 mg/vials or _____ mg

Pre–Meds:

- Benadryl: _____mg ○ PO ○ IVP
- Acetaminophen: _____mg ○ PO ○ IVP
- Other: _____ _____mg ○ PO ○ IVP

Sig: Infuse ○ 5mg/kg ○ 10mg/kg

NS 0.9% 250ml every _____ weeks or as directed

Prescriber Notes

Physician's Signature:_____ **Date:**_____ **Time:**_____ **AM/PM**

Fax completed form to Hunt Regional Infusion Center at (903) 455–8773. PLEASE include copies of ALL patients' current insurance cards to expedite benefit verification. Also forward any lab work, Letter of Medical Necessity and any other supporting documentation supporting the use of Infusion Therapy.