MIC | METRO INFUSION CENTER

Phone: 877.448.3627

Fax completed form to:
866-507-1164

INFUSION ORDERS — REMICADE (infliximab)

Date of referral: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ WT (kg): _____ HT: _____(in)

Diagnosis: _____

Allergies: _____ TB Test Results: _____

***ICD 10 CODE:** _____

***Please include supporting clinical documentation for specified ICD 10 Code as well as demographic and insurance information. This must be provided to ensure payment by insurance carrier. Please fax with this order form.**

Initial appointment date and time will be verified after insurance approval.

REMICADE DOSING

- ☐ Remicade dose of 3mg/kg
- ☐ Remicade dose of 5mg/kg
- ☐ Remicade dose of 7.5mg/kg
- ☐ Remicade dose of 10mg/kg
- ☐ Remicade specific dose of _____

Frequency

- ☐ Loading dose of day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter
- ☐ Specific dosing frequency of _____ _____

Premedication of: _____

Prescribing Physician: _____

Address: _____

Physician Signature: _____

Date: _____

Physician Phone: _____ Fax: _____