AYSA
THERAPEUTICS INFUSION

REMICADE (INFLIXIMAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ☐ Rheumatoid Arthritis (_____) ☐ Ankylosing Spondylitis (_____)

☐ Crohn's Disease (_____) ☐ Ulcerative Colitis (_____)

☐ Psoriasis (_____) ☐ Other: _____ (_____)

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

☐ TB and Hepatitis B documentation, CBC and liver function should be followed at regular intervals

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

REMICADE ORDERS

Remicade Dose: _____ mg/kg **Frequency:** Every: _____ weeks or ☐ 0, 2, 6, then every 8 weeks

Protocol Pre-Medication Orders: Tylenol 1000mg PO, *please choose one antihistamine:*

☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP

☐ TB Test Attached ☐ Perform TB testing

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(optional)*

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required.

**** Date of last** ☐ Remicade ☐ Orencia ☐ Humira ☐ Enbrel dose: _____

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____