Remicade Order Form

Pre-filled order form for Remicade (infliximab) — TNF inhibitor for inflammatory arthritis and IBD

REFERRING PROVIDER

PROVIDER NAME | NPI | DEA (IF CONTROLLED) | SPECIALTY

PRACTICE / CLINIC NAME | OFFICE PHONE | OFFICE FAX

OFFICE CONTACT NAME | CONTACT PHONE | CONTACT EMAIL

PATIENT INFORMATION

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | SEX | PATIENT PHONE | BEST TIME TO CONTACT

ADDRESS | CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE | MEMBER ID | GROUP #

SECONDARY INSURANCE (IF ANY) | MEMBER ID | GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS | ICD-10 CODE

SECONDARY DIAGNOSIS (IF APPLICABLE) | ICD-10 CODE

Common indications for this medication: *Rheumatoid arthritis, Crohn's disease, Ulcerative colitis, Ankylosing spondylitis, Psoriatic arthritis, Plaque psoriasis*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME

REMICADE REFERENCE

Generic name:	infliximab
Specialty:	Rheumatology & Gastroenterology
Typical infusion time:	2–3 hours per infusion
Typical schedule:	Loading at weeks 0, 2, 6 — then every 6–8 weeks
Biosimilars / brands:	Inflectra, Renflexis, Avsola

MEDICATION ORDER

MEDICATION (DEFAULT: REMICADE) | **GENERIC / ALT (INFLIXIMAB)** | **STRENGTH / FORMULATION**

DOSE | **FREQUENCY (TYPICAL: LOADING AT WEEKS 0, 2, 6 — THEN EVERY 6&NDASH;8 WEEKS)** | **DURATION (TYPICAL: 2&NDASH;3 HOURS PER INFUSION)**

ROUTE | **PRE-MEDICATIONS (IF ANY)** | **SPECIAL INSTRUCTIONS**

ANTICIPATED START DATE | **# OF DOSES AUTHORIZED** | **SUBSTITUTION ALLOWED (Y/N)** | **BIOSIMILAR ACCEPTABLE (Y/N)**

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Ascribe to verify before each infusion:

- ☐ CBC w/ differential
- ☐ CMP
- ☐ Liver function panel
- ☐ Hepatitis B/C panel
- ☐ TB screen (T-SPOT or QFT)
- ☐ Pregnancy test (urine)
- ☐ Iron studies (ferritin, TSAT)
- ☐ Vitamin levels (B12, D, folate)
- ☐ Other (specify below)

OTHER LABS / MONITORING REQUIREMENTS

PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Ascribe Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE | **PRINTED NAME** | **DATE**

Form code: ARB-ORDER-REMICADE · Submit to Ascribe Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Ascribe Infusion will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@ascribeinfusion.com