TALIS HEALTHCARE

Return Completed Form To:
888.898.9113

INFUSION ORDER – REMICADE (Infliximab)

Patient First Name: _____ Patient Last Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Referral Date: _____ Weight (kg): _____ Height (in): _____

Diagnosis: _____

Allergies: _____ TB Test Results: _____

REMICADE DOSING

- ☐ Remicade dose of 3mg/kg
- ☐ Remicade dose of 5mg/kg
- ☐ Remicade dose of 7.5mg/kg
- ☐ Remicade dose of 10mg/kg
- ☐ Remicade 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: _____ City: _____ State: _____ Zip: _____

Physician Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

ICD 10 CODE: _____

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.