

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 Arbor to verify before each infusion:

- | | | |
|--------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> CBC w/ differential | <input type="checkbox"/> CMP | <input type="checkbox"/> Liver function panel |
| <input type="checkbox"/> Hepatitis B/C panel | <input type="checkbox"/> TB screen (T-SPOT or QFT) | <input type="checkbox"/> Pregnancy test (urine) |
| <input type="checkbox"/> Iron studies (ferritin, TSAT) | <input type="checkbox"/> Vitamin levels (B12, D, folate) | <input type="checkbox"/> 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. Arbor 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 Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com