

**Patient information**

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

Mobile number \_\_\_\_\_

Weight \_\_\_\_\_  kgs  lbs

- Diagnosis**
- Rheumatoid arthritis
  - Plaque psoriasis (I40.0)
  - Plaque arthritis
  - Ankylosing spondylitis
  - Crohn's disease
  - Ulcerative colitis
  - Other \_\_\_\_\_

**Allergies**  NKDA  \_\_\_\_\_

**Medication instructions**

- Pre-medications**  N/A  
 Provider prescribed: \_\_\_\_\_

- |                         |  |  |
|-------------------------|--|--|
| <b>Medication order</b> | <b>Dose</b>  | <b>Frequency</b>   |
|                         | <input type="checkbox"/> Infliximab (remicade)       | <input type="checkbox"/> Weeks 0, 2, 6, and then every 8 weeks |
|                         | <input type="checkbox"/> Infliximab-dyyb (inflectra) | <input type="checkbox"/> Every 8 weeks                         |
|                         | <input type="checkbox"/> Infliximab-qbtx (ixifi)     | <input type="checkbox"/> Other _____                           |
|                         | <input type="checkbox"/> Infliximab-abda (renflexis) |  |
|                         | <input type="checkbox"/> Other _____                 |  |

- Medication route**  IV  
 Other \_\_\_\_\_

- Lab order**  
(Include frequency) Please list any labs to be drawn by the infusion clinic:  
 N/A  
 \_\_\_\_\_

**Prerequisites** Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Negative TB results | Negative Hep B results

- Please send to**  Columbia, MD  Silver Spring, MD  Bowie, MD  Frederick, MD

**Referring provider information**

Referring provider name \_\_\_\_\_ NPI \_\_\_\_\_

Practice name \_\_\_\_\_

Point of contact Name \_\_\_\_\_ Email \_\_\_\_\_ Phone \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_