SPRINGSIDE INFUSION

Remicade and biosimilars

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis

☐ Rheumatoid arthritis
☐ Plaque psoriosis (l40.0)
☐ Plaque arthritis
☐ Ankylosing spondylitis
☐ Crohn's disease
☐ Ulcerative colitis
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications

☐ N/A
☐ Provider prescribed: _____

Medication order

Dose

☐ Infliximab (remicade)
☐ Infliximab-dyyb (inflectra)
☐ Infliximab-qbtx (ixifi)
☐ Infliximab-abda (renflexis)
☐ Other _____

Frequency

☐ Weeks 0, 2, 6, and then every 8 weeks
☐ Every 8 weeks
☐ 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 _____