

Remicade® (Infliximab) Referral Form



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Patient Information			
Patient Name:	Patient DOB:		
Referral Status			
<input type="checkbox"/> New Referral	<input type="checkbox"/> Restart	<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> D/C Infusions
Diagnosis and ICD 10 Code			
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90		
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90		
<input type="checkbox"/> Rheumatoid Arthritis	ICD 10 Code: M06.9		
<input type="checkbox"/> Ankylosing Spondylitis	ICD 10 Code: M45.9		
<input type="checkbox"/> Psoriatic Arthritis	ICD 10 Code: L40.52		
<input type="checkbox"/> Plaque Psoriasis	ICD 10 Code: K50.90		
<input type="checkbox"/> Other Diagnosis:	ICD 10 Code:		
Required Documentation			
<input type="checkbox"/> Patient demographics	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis		
<input type="checkbox"/> Copy of patient insurance card(s) – front & back	<input type="checkbox"/> Labs and tests supporting primary diagnosis		
<input type="checkbox"/> Tried and Failed therapies	<input type="checkbox"/> TB and Hepatitis B test results: HBsAg Total HebB Core Antibody		
Medication Orders			
Induction/Maintenance Dosing Remicade®:			
<input type="checkbox"/> 3mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter			
<input type="checkbox"/> 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter			
Maintenance Dose Remicade®:			
<input type="checkbox"/> 3 mg/kg IV every 8 weeks			
<input type="checkbox"/> 5mg/kg IV every 8 weeks			
Patient Weight =	kg		
Notes (Additional Info)			
Premedication, adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.			
Prescriber Information			
Prescriber Name:	NPI #:		
Office Contact:	Office Phone:	Office Fax:	
Prescriber Signature:	Date:	(Order is valid for one year)	
My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.			
Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.			

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