MONTGOMERY CANCER CENTER
A BAPTIST MEDICAL CENTER SOUTH FACILITY

MEDICATION ORDERS

REMICADE (INFLIXIMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
❑ New Referral	❑ Dose or Frequency Change	❑ Order Renewal

INFUSION OFFICE PREFERENCE (Optional)		
Preferred Location:	❑ Montgomery	❑ Prattville

DIAGNOSIS AND ICD 10 CODE	
❑ Ankylosing Spondylitis	ICD 10 Code: M45.9
❑ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
❑ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
❑ Plaque Psoriasis	ICD 10 Code: L40.0
❑ Psoriatic Arthritis	ICD 10 Code: L40.52
❑ Rheumatoid Arthritis	ICD 10 Code: M06.9
❑ Other:_____	ICD10 Code: _____

REQUIRED DOCUMENTATION/TESTING	
❑ This signed order form by the provider	❑ Clinical/ Progress notes
❑ Patient demographics AND insurance information	❑ Labs and tests supporting primary diagnosis
❑ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	❑ TB Test Results

List tried AND failed therapies, including duration of treatment:
1)
2)
3)

MEDICATION ORDERS	
Initial Dosing:	❑ Remicade 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter
Maintenance Dosing:	❑ Remicade 5mg/kg IV every 8 weeks
Alternative Dosing:	❑ Remicade_____ IV every_____ weeks

Refills: ❑ x 6 months ❑ x 1 year ❑ _____ doses

- New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.
- Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PREMEDICATIONS
✓ Acetaminophen 1000mg PO prior to Remicade infusion
✓ Diphenhydramine 25mg IVP prior to Remicade infusion
❑ Other: _____

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207

All information contained in this form is strictly confidential and will become part of the patient's medical record.