Phone: (305) 306-7147 | Fax: (305) 402-9559 | Email: contact@clearwellinfusion.com

Clearwell
Infusion Centers

REMICADE (infliximab)

PATIENT DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____ M: ☐ F: ☐ Address: _____

Phone: _____ City, State, Zip: _____

Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

- ☐ TB status & date (attach results)
- ☐ Hepatitis B status & date (attach results)
- ☐ CBC and liver function should be monitored

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

- ☐ Acetaminophen 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Ceterizine 10mg PO
- ☐ Loratadine 10mg PO
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ Other:

PRIMARY MEDICATION ORDER

Dosage

- ☐ _____ mg/kg (weight-based)
- ☐ _____ mg (flat-dosed)

Patient Weight:

_____ lbs

_____ kg

Frequency

- ☐ week 0,2,6, and every 8 weeks
- ☐ every _____ weeks

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____

Practice Name: _____ Phone: _____

Office Contact: _____ Fax: _____

Practice Address: _____

City, State, Zip: _____

Provider Signature: _____ Date: _____