



REMICADE ORDERS

Phone: 866.972.5888 | Fax: 866.491.5888

Patient Name: _____ DOB: _____ Sex: M F
 Address: _____ Patient SSN: _____
 City: _____ State: _____ Zip: _____ Phone: _____
 Demographics Attached

INSURANCE INFORMATION

copy of card(s) attached

Primary Insurance: _____ Phone: _____
 Cardholder Name: _____ ID# _____ Group# _____
 Employer: _____ DOB: _____ Relationship: _____

Secondary Insurance: _____ Phone: _____
 Cardholder Name: _____ ID# _____ Group# _____
 Employer: _____ DOB: _____ Relationship: _____

MEDICAL INFORMATION

Diagnosis: Crohns Disease Ulcerative Colitis Rheumatoid Arthritis Plaque Psoriasis
 Other: _____

First Dose: YES NO

Patient Weight: _____ **Height:** _____ **Allergies:** _____

TB/PPD Test given or intended to be given before start date? YES NO Date: _____

Test Results: _____

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required. Date: _____

Results: _____

ORDERS

Remicade _____mg/kg _____mg IV per protocol (to be rounded up to nearest 100mg vial)

**Recommended starting dose per packet insert: Crohns 5mg/kg, UC 5mg/kg, RA 3mg/kg, PP 5mg/kg

Frequency: _____ 0, 2wk, 6wk, followed by every 8 weeks

_____ 0, 2wk, 6wk, followed by every 6 weeks

Pre-Meds and/or PRNs

Tylenol 650mg PO Tylenol 1gm PO Benadryl 25mg PO or IV Benadryl 50mg PO or IV

Solumedrol _____mg IV Epinephrine 1 : 1000 0, 2-0.5ml SC or IV for anaphylaxis

Other: _____

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

NPI: _____ DEA: _____ License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Contact Person: _____

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