



MOUNTAIN GRACE
HOME INFUSION

+1 833-360-1212 info@mginfusion.com

+1 (760) 400-6905

REMICADE

Date of order: _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Update Order ☐ Order Renewal ☐ Home Infusion

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ K50. _____ ☐ K51. _____ ☐ M06.00
☐ M05.6 ☐ M05.70 ☐ M45.9 ☐ L40.50 ☐ L40.0 ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: info@managecaresolutions.com

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

NURSING

- ☒ Center will use Hypersensitivity protocol established by Mountain Grace Home Infusion and PI
- ☒ TB Results (list results/date & attach clinicals): _____
- ☒ Hepatitis B Status & Date (list results & attach clinicals): _____

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other _____ ☐ Frequency _____
- ☐ Please check this box if you DO NOT authorize Mountain Grace Home Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- ☒ Infliximab Intravenous Infusion
- Dose::**
Weight Based: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg
OR ☐ Total dose = _____ mg
- ☐ Other: _____
- ☐ Round UP to the nearest 100mg vial OR ☐ Give exact dose
- ☐ Rapid infusion (over one hour) starting after first maintenance infusion
- Frequency:**
- ☐ Induction: Week 0, 2, and 6
- ☐ Maintenance: Every ☐ 4 weeks / ☐ 6 weeks / ☐ 8 weeks
- ☐ Other: _____
- ☐ Refills: ☐ Zero/ ☐ for 12 months/ ☐ _____
(if not indicated order will expire one year from date signed)
- To receive the brand-name medication, the prescribing provider must clearly write "Brand Medically Necessary" on the prescription. If this notation is absent, I4H may dispense an FDA-approved generic equivalent or biosimilar, when available.*

PRE- MEDICATION ORDERS

Pre-meds not usually indicated

- ☐ Diphenhydramine ☐ 25mg / ☐ 50 mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650 mg ☐ PO
- ☐ Other: _____
- Dose: _____ Route: _____ Frequency:: _____

SPECIAL INSTRUCTIONS:

Provider Name (Print) : _____

Provider Signature : _____

Date : _____

Please send it to this email: info@mginfusion.com