The Outpatient Infusion Center
a Service of Comanche County Memorial Hospital

Phone: 580-355-8620 ext 6194
Fax: 580-585-5472

Fax ***completed*** order form to the **Outpatient Infusion Center: 580-585-5472**. Please **INCLUDE** copies of: **H&P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, LETTER OF NECESSITY, ALL CURRENT INSURANCE INFORMATION**, and any other documentation supporting the use of infusion therapy for your referral to be processed.

REMICADE/INFLECTRA ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
HT: _____ WT: _____ DOB: _____ □ Male □ Female SSN:_____
Street Address_____ City/State/Zip _____
Home Phone # _____ Work # _____ Cell # _____
Allergies:_____
_____

INSURANCE INFORMATION

Primary Insurance Name_____ Policy ID# _____
Secondary Insurance Name_____ Policy ID# _____

PHYSICIAN/FACILITY INFORMATION

Physician's Name_____ Contact Name _____
Contact Phone # _____ Fax # _____
Address _____ City/State/Zip_____
DEA# _____ NPI # _____ State License # _____

REQUIRED STATEMENT OF MEDICAL NECCESITY

Primary Diagnosis (ICD 10 code ***AND*** CPT code): _____
Secondary Diagnosis (ICD 10 code ***AND*** CPT code): _____

PRESCRIPTION ORDERS: □ REMICADE OR □ INFLECTRA

All doses will be rounded to the nearest 100mg vial
All mediports/ports/VAD will be flushed with Heparin per hospital protocol
50 mL bag of normal saline will be hung to clear all patient lines

□ Initial dose: _____mg/kg IV on day 0, 2 weeks, 6 weeks, and then every _____ weeks
□ Maintenance dose: _____mg/kg IV every _____ weeks

PRN MEDICATIONS:
□ Bendaryl PRN: _____ mg □ PO □ IV □ IVP □ Other: _____
□ Acetaminophen PRN: _____ mg □ PO □ IV □ IVP □ Oxygen:_____

FLUSHES:
□ Heparin 500 units/5 mL flush syringe PRN □ 10 mL Normal Saline flush syringe PRN
□ 50 mL Normal Saline PRN □ 250 mL Normal Saline PRN

Notes:_____
_____
_____
_____

Physician's Signature _____ **Date & Time:** _____