

MPP Infusion Centers

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Email To: MPPReferral@mppinfusion.com

Have a Question? Call: (855) 478-1528

A Multispecialty Physician Partner Company

RENFLEXIS® (INFLIXIMAB) ORDER FORM

REFERRAL STATUS			
<input type="checkbox"/> New Referral <input type="checkbox"/> Order Renewal <input type="checkbox"/> Restart <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> D/C Infusion (Medication(s) to D/C _____)			
LOCATION			
<input type="checkbox"/> Denver <input type="checkbox"/> Arlington <input type="checkbox"/> Dallas <input type="checkbox"/> Duncanville <input type="checkbox"/> Irving <input type="checkbox"/> Lewisville <input type="checkbox"/> Plano <input type="checkbox"/> Southlake <input type="checkbox"/> Tyler			
PATIENT INFORMATION			
PATIENT NAME:		DOB:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS:		PHONE #:	
WEIGHT: _____ LBS _____ KG	HEIGHT:		EMAIL:
ALLERGIES:			
Please check that the following are included	<input type="checkbox"/> Patient demographics and insurance attached		<input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	<input type="checkbox"/> Current Medication List		<input type="checkbox"/> TB Results (w/in 6 months)-if positive, need negative chest Xray and negative TSpot
	<input type="checkbox"/> HepB Surf Ag (w/in 36 months) (For IBD diagnosis w/in 12 months)		<input type="checkbox"/> HepB Core (w/in 36 months) (For IBD diagnosis w/in 12 months)
PHYSICIAN INFORMATION			
Physician Name:		Email (if you would like referral updates):	
Practice Name:		Phone Number:	
Office Contact:		Fax Number:	
DIAGNOSIS			
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other:	
<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Ankylosing Spondylitis		
<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Plaque Psoriasis		
ICD-10 CODE:		Date of last infusion/injection:	
MEDICATION ORDERS			
RENFLEXIS ORDERS:			Notes/Comments
<input type="checkbox"/> Initial Dose: _____ mg/kg IV on day 0, 2 weeks, 6 weeks and then every _____ weeks.			
<input type="checkbox"/> Maintenance Dose: _____ mg/kg IV every _____ weeks.			
Physician Signature _____		Date (Order is Valid for One Year) _____ Infusion will be administered per MPP policy and protocol	
STANDING LAB ORDERS			
_____ Labs to be Drawn by Infusion Center		Frequency: _____ Every Infusion _____ Other (please specify) _____	
<input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> CRP <input type="checkbox"/> ESRP <input type="checkbox"/> HFR <input type="checkbox"/> UA			
MPP REMICADE ORDER FORM_01/2019			