

Effective: 10/2016

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191

Denver Arlington Dallas Duncanville Irving Lewisville Plano Southlake

New Referral Restart Medication/ Order Change
(New Order Required) Benefits Verification Only D/C Infusions
**indicate name of drug(s)*

PATIENT INFORMATION

PHYSICIAN INFORMATION

Name: _____ Date: _____
DOB: _____ SS# _____
Phone # _____
Email: _____

Referring Physician: _____
Practice Name: _____
Specialty: _____
Office Contact: _____
Contact Phone # _____ Contact Fax # _____
Contact Email: _____

INFLECTRA MEDICATION ORDERS

Patient Weight: _____ kg Initial/Reload Dosing: _____ mg/kg IV on day 0, 2 weeks, 6 weeks then every _____ weeks.
Maintenance Dosing: _____ mg/kg IV every _____ weeks.

INDICATION/DIAGNOSIS

NOTES (ADDITIONAL INFO)

Crohn's Disease Ankylosing Spondylitis
Rheumatoid Arthritis Ulcerative Colitis
Psoriatic Arthritis Other *(please specify in notes)*

*ICD-10 _____ required

Referring Physician's Signature Date

STANDING LAB ORDERS

Labs to be drawn by:	Orders:	Frequency:
Referring Physician	CMP CBC CRP	Every Infusion
Infusion Center	ESRP HFP UA	Other _____

REQUIRED DOCUMENTATION

Recent Office notes (along with any therapies tried and outcomes) Current Medication List History and Physical Report (w/in past 6 months)
Lab Results Insurance Cards (front and back) Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

HepB Surf Ag (w/in 12 months) HepB Core Ab (w/in 12 months) PPD Results (w/in 6 months) Rheumatoid Factor
Chest X-ray (if indicated) Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY