(infliximab)

REMICADE infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis
- ☐ _____ Psoriatic Arthritis
- ☐ _____ Plaque Psoriasis
- ☐ _____ Ankylosing Spondylitis
- ☐ _____ Crohn's Disease
- ☐ _____ Ulcerative Colitis
- ☐ _____ _____

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*
- ☐ Length of Need _____

REMICADE ORDERS

DOSAGE

- ◯ _____ mg/kg *weight-based*
- ◯ _____ mg *flat-dosed*

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

- ◯ every 0,2,6, and every 8 weeks *(induction)*
- ◯ every _____ weeks
- ◯ Refills: _____

Notes

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887