Fax To: (888) 978-7869
1959 W. 9th Street, Suite A
West Palm Beach, FL 33404
Phone: (800) 499-6579

REMICADE® (INFLIXIMAB) ORDER FORM

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: M F
ADDRESS:		PHONE #:
WEIGHT: LBS KG	HEIGHT:	EMPLOYER:
HISTORY OF CHF: NO YES CLASS (I-IV):		DATE OF LAST PPD: RESULT:
ALLERGIES:		

Patient demographics and insurance attached

Clinical/Progress Notes, Labs, Tests supporting DX Attached

TB Screening and Hepatitis B Vaccine or testing documentation attached

DIAGNOSIS

Crohn's Disease ICD-10 CODE:	Rheumatoid Arthritis ICD-10 CODE:
Ulcerative Colitis ICD-10 CODE:	Alkylosing Spondylitis ICD-10 CODE:
Psoriatic Arthritis ICD-10 CODE:	Plaque Psoriasis ICD-10 CODE:

Other:

MEDICATION ORDERS

PREMEDICATION ORDERS:

Diphenhydramine (Benadryl):	25mg IVP	50 mg IVP	Other Dose:
Acetaminophen:	650 mg PO	Other Dose:	
Solu-Medrol:	125 mg IVP	Other Dose:	

FLUSH ORDERS:

Flush with 0.9% NaCl and Heparin 10u/ml or Heparin 100u/mL PRN as per protocol.

Other Flush Orders:____

REMICADE/INFLIXIMAB ORDERS:

Initial Dose: ________________mg/kg IV on day 0, 2 weeks, and 6 weeks. Infused over at least 2 hours (see titration schedule)

Maintenance Dosing: _____________mg/kg IV every _______ weeks. Infused over at least 2 hours (see titration schedule)

Date of last infusion:___________________

ANAPHYLACTIC KIT

OTHER PHARMACY ORDERS:

Titration Schedule
10 ml/hr x 15 mins
20 ml/hr x 15 mins
40 ml/hr x 15 mins
80 ml/hr x 15 mins
150 ml/hr x 30 mins
250 ml/hr x 30 mins

NURSING/HOME HEALTH ORDERS

Standard Nursing Orders

- ✓ Weight taken before each dose
- ✓ Monitor Pulse/BP before therapy and every 15-30 minutes until 30 minutes after therapy
- ✓ If infusion reaction occurs, decrease rate and monitor vitals until symptoms subside. If reaction persists or worsens, stop infusion and notify Physician.
- ✓ Observe patient for 30 minutes after completion of therapy.

Other: ____

LAB ORDERS:

CBC with Diff	at each dose	every _________
Hepatic Function Panel	at each dose	every _________
CRP	at each dose	every _________

Other Lab:

PHYSICIAN INFORMATION

Physician Name:		Office Contact:
UPIN#:	License #	Phone Number:
Prescriber Signature:		Date: