

(infliximab)

# REMICADE infusion orders

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

**DIAGNOSIS** *Please provide ICD-10 code*

\_\_\_\_\_ Rheumatoid Arthritis  
 \_\_\_\_\_ Psoriatic Arthritis 6 yro (PJA)  
 \_\_\_\_\_ Plaque Psoriasis  
 \_\_\_\_\_ Ankylosing Spondylitis  
 \_\_\_\_\_ Crohn's Disease  
 \_\_\_\_\_ Ulcerative Coliti  
 \_\_\_\_\_ \_\_\_\_\_ (other)

**PRE-MEDICATION**

Tylenol 1000mg PO                       Solu-Medrol 125mg IVP  
 Diphenhydramine 25mg PO             Solu-Cortef 100mg IVP  
 Cetirizine 10mg PO                       Diphenhydramine 25mg IVP  
 \_\_\_\_\_ (other)                               \_\_\_\_\_ (other)

**REMICADE ORDERS**

**PATIENT WEIGHT**

\_\_\_\_\_ lbs.  
\_\_\_\_\_ kg

**DOSAGE:**

\_\_\_\_\_ mg/kg / IV *weight - based*  
 \_\_\_\_\_ mg *flat dosed*

**Frequency:**

Every, 0,2,6, and every 8 weeks (*induction*)  
 Every \_\_\_\_\_ weeks  
 Quant \_\_\_\_\_  
 Total dosage /refills \_\_\_\_\_

**NOTES/ADDITIONAL COMMENTS:**

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**ORDERING PROVIDER**

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_