

(influximab)
REMICADE infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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 <i>Please provide ICD-10 code</i> ☐ _____ Rheumatoid Arthritis ☐ _____ Psoriatic Arthritis 6 yro (PJA) ☐ _____ Plaque Psoriasis ☐ _____ Ankylosing Spondylitis ☐ _____ Crohn's Disease ☐ _____ Ulcerative Coliti ☐ _____ (other) PRE-MEDICATION <table><tbody><tr><td>☐ Tylenol 1000mg PO</td><td>☐ Solu-Medrol 125mg IVP</td></tr><tr><td>☐ Diphenhydramine 25mg PO</td><td>☐ Solu-Cortef 100mg IVP</td></tr><tr><td>☐ Cetirizine 10mg PO</td><td>☐ Diphenhydramine 25mg IVP</td></tr><tr><td>☐ _____ (other)</td><td>☐ _____ (other)</td></tr></tbody></table>	☐ 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 <i>weight - based</i> ☐ _____ mg <i>flat dosed</i> Frequency: ☐ Every, 0,2,6, and every 8 weeks (<i>induction</i>) ☐ Every _____ weeks ☐ Quant _____ ☐ Total dosage ☐ /refills _____
☐ Tylenol 1000mg PO	☐ Solu-Medrol 125mg IVP								
☐ Diphenhydramine 25mg PO	☐ Solu-Cortef 100mg IVP								
☐ Cetirizine 10mg PO	☐ Diphenhydramine 25mg IVP								
☐ _____ (other)	☐ _____ (other)								

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____