

(infliximab)

REMICADE infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

NPI _____ Tax ID _____

☐ Allergies _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

REFERRAL STATUS

- ☐ New Prescription
- ☐ Order Renewal
- ☐ Does or Frequency Change
- ☐ Discontinuation

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
- ☐ _____

- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

REMICADE ORDERS

DOSAGE

- ☐ _____ mg/kg / IV *weight-based*
- ☐ _____ mg *flat-dosed*

FREQUENCY

- ☐ every 0,2,6, and every 8 weeks (*induction*)
- ☐ every _____ weeks

PATIENT WEIGHT

_____ lbs.
_____ kg

- ☐ total dosage _____
- ☐ refill _____

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____