

(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

- | | |
|---|---|
| <input type="checkbox"/> _____ Rheumatoid Arthritis | <input type="checkbox"/> _____ Crohn's Disease |
| <input type="checkbox"/> _____ Psoriatic Arthritis | <input type="checkbox"/> _____ Ulcerative Colitis |
| <input type="checkbox"/> _____ Plaque Psoriasis | <input type="checkbox"/> _____ _____ |
| <input type="checkbox"/> _____ Ankylosing Spondylitis | |

PRE-MEDICATION

- | | |
|--|---|
| <input type="checkbox"/> Tylenol 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

REMICADE ORDERS

DOSAGE <input type="radio"/> _____ mg/kg / IV <i>weight-based</i> <input type="radio"/> _____ mg <i>flat-dosed</i>	PATIENT WEIGHT _____ lbs. _____ kg
FREQUENCY <input type="radio"/> every 0,2,6, and every 8 weeks (<i>induction</i>) <input type="radio"/> every _____ weeks	<input type="checkbox"/> total dosage _____ <input type="checkbox"/> refill _____

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____