(infliximab)

REMICADE infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

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 *weight-based*
- ○ _____ mg *flat-dosed*

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

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

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____