Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

REMICADE ORDER
(Infliximab)

Please fax a copy of patient's demographics, insurance information, current lab results including TB & Hep B, H&P relevant to the diagnosis & current medications.

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ICD-10: _____

TB test date: _____ result: _____ Hepatitis B date: _____ result: _____

PRE-MEDS:	**Benadryl**	☐ **PO** ☐ **IV**	☐ **25mg**	☐ **50mg**	☐ **Pre med**	☐ **PRN**
	Acetaminophen	☐ **PO**	☐ **325mg**	☐ **650mg**	☐ **Pre med**	☐ **PRN**
	☐ **Claritin** ☐ **Zyrtec**	☐ **PO**	☐ **10mg**		☐ **Pre med**	☐ **PRN**
	Solu-Medrol	☐ **IV**	**_____mg**		☐ **Pre med**	☐ **PRN**
	Normal Saline Bolus	☐ **IV**	**250 mL**		☐ **Pre med**	☐ **PRN**
	Zofran	☐ **PO** ☐ **IV**	**_____ mg**		☐ **Pre med**	☐ **PRN**

Remicade (Infliximab) IV Dosing

☐ **3 mg/kg** ☐ **5 mg/kg** ☐ **7.5 mg/kg** ☐ **10 mg/kg**

☐ **Round to nearest vial (100 mg per vial)**
☐ **Pediatric; weight based dosing per visit**
OR
☐ **Total dose = _____ mg**

Frequency: ☐ **Initial dose at 0, 2, 6 weeks, then** ☐ **Q 4 weeks** ☐ **Q 6 weeks** ☐ **Q 8 weeks**

Next dose due: _____/_____/_____

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office phone number: _____ Office Fax:_____

Office address: _____Contact person: _____

Revised 10/19/17