Remicade Order
(infliximab)

InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current CBC & CMP ☐ H & P Relevant to Diagnosis ☐ Current Medications ☐ TB & Hep B Results ☐ Colonoscopy/Pathology (GI only)

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

TB Test Date: _____ Result: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Hep B Date: _____ Result: _____

PRE-MEDICATIONS:

Benadryl:	☐ PO	☐ IV	☐ 25mg	☐ 50mg	☐ Pre-med	☐ PRN
Acetaminophen:			☐ 325mg	☐ 650mg	☐ Pre-med	☐ PRN
Zyrtec			☐ 10mg		☐ Pre-med	☐ PRN
Solu-Medrol:		☐ IV	☐ _____ mg		☐ Pre-med	☐ PRN
Dexamethasone:		☐ IV	☐ 10mg	☐ 5mg	☐ Pre-med	☐ PRN

REMICADE (INFLIXIMAB) IV DOSING

Date of Last Treatment, If Continuation:

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

☐ Round to the nearest vial (100mg 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: _____