# Remicade Order
## (Infliximab)

INFUSION FOR HEALTH
Ph: 805-719-3700 | Fax: 805-852-2636

Date: ____ / ____ / ____ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Current Medications ☐ TB & Hep B Results

### 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: _____

Hep B Date: ____ / ____ / ____ Result: _____

### PRE-MEDICATIONS:

| | | | | | | |
|---|---|---|---|---|---|---|
| Benadryl: | ☐ PO | ☐ IV | ☐ 25mg | ☐ 50mg | ☐ Pre-med | ☐ PRN |
| Acetaminophen: | ☐ PO | | ☐ 325mg | ☐ 650mg | ☐ Pre-med | ☐ PRN |
| ☐ Claritin or ☐ Zyrtec | ☐ PO | | ☐ 10mg | | ☐ Pre-med | ☐ PRN |
| Solu-Medrol: | | ☐ IV | ☐ _____ mg | | ☐ Pre-med | ☐ PRN |
| Normal Saline Bolus: | | ☐ IV | ☐ 250mL | | ☐ 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: ____ / ____ / ____

Revised 12/01/20