



Remicade (Infliximab) Infusion Order Form

Patient Information

Patient Name: _____ DOB: _____ M F

Allergies: _____

New Treatment Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

- | | |
|---|---|
| <input type="checkbox"/> Moderate to Severe Ulcerative Colitis ICD 10 Code: K51.90 | <input type="checkbox"/> Ankylosing Spondylitis ICD 10 Code: M45.9 |
| <input type="checkbox"/> Moderate to Severe Crohn's Disease ICD 10 Code: K50.90 | <input type="checkbox"/> Psoriatic Arthritis ICD 10 Code: L40.52 |
| <input type="checkbox"/> Rheumatoid Arthritis ICD 10 Code: M06.9 | <input type="checkbox"/> Plaque Psoriasis ICD 10 Code: L40.0 |
| <input type="checkbox"/> Other: _____ ICD 10 Code: _____ | |

Required Tests (within 12 months & attach results)

TB/ Quantiferon Status & Date: _____

Hepatitis B Status & Date: _____

Required Labs (within 3 months & attach results)

CBC Results _____

CMP Results _____

CRP Results _____

Other: _____

Pre-Medication Orders

Acetaminophen (Tylenol) 500mg 650mg 1000mg PO

Diphenhydramine (Benadryl) 25mg 50mg PO IV

Methylprednisolone (Solu-Medrol) 125mg IV

Ondansetron (Zofran) 4mg 8mg PO IV

Other: _____ Route: _____

Dose: _____ Frequency: _____

Nursing

Provide nursing care per Smart Infusion Nursing Procedures,
Including reaction management and post-procedure observation.

Special Instructions / Notes

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____

Remicade Medication Orders

Patient Weight: _____ KG

Dosage

3mg/kg IV 5mg/kg IV 10mg/kg IV

_____ mg/kg

Frequency

Induction week 0, 2, 6 then every 8 weeks

Maintenance every 8 weeks

Other _____

Required Documents

Patient Demographic Sheet

H & P within the past 6 months

Current Medication List

Clinical and Progress Notes