



## 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       |

### Required Labs

TB/QuantIFERON (within 12 months & attach results)  
Hepatitis B Status & Date: \_\_\_\_\_  
Most recent CBC & CMP (attach results)

### 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

### **Remicade Medication Orders**

**Patient Weight:** \_\_\_\_\_ KG

#### Dosage

- 3mg/kg IV     5mg/kg IV     10mg/kg IV  
 \_\_\_\_\_ mg/kg

We will round to the nearest full vial unless checked no

#### 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 & Progress Notes (including last infusion note)  
 Copy of Insurance Card (Front/Back)

### **Location**

- Eau Claire     Weston     Middleton

### **Provider Information**

Provider Name: \_\_\_\_\_    Provider NPI: \_\_\_\_\_

Office Phone: \_\_\_\_\_    Office Fax: \_\_\_\_\_

Provider Signature: \_\_\_\_\_    Date: \_\_\_\_\_