Intravene – Remicade Infusion Orders (rev 10/2018)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434) 455-5531 or call (434) 947-3900 ext. 3001

PATIENT INFORMATION

Name ______________________________

Address ____________________________

City _______________________________

State _____________ Zip Code ________

Home Phone # ________________________

Work Phone # ________________________

DOB _________SSN __________________

Height ___________ Weight ________lbs

Drug Allergies______________________

□ NKDA Sex: □ Male or □ Female

REFERRING PHYSICIAN INFORMATION

Physician Name ____________________________

Physician Address__________________________

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Physician Phone(_____)_____________________

Physician Fax(____)________________________

NPI#__________________DEA#_____________

State License#______________________________

****Please fax copies of insurance cards** and this form to 434-455-5531**

DIAGNOSIS: (ICD-10 required)

- ☐ ______________________________ ______________________________
- ☐ ______________________________ ☐ ______________________________
- ☐ ______________________________ ______________________________
- ☐ ______________________________ ______________________________

Please Mark One

□ Patient **IS** on methotrexate **OR** □ Patient is **NOT** on methotrexate

PRE TREATMENT SCREENING:

Tuberculosis Screening: Date/Results of TB test_______________

Hepatitis B Screening: Date/ Results:__________________

Hepatitis C Screening: Date/Results:___________________

STANDARD ORDERS:

Infuse Remicade ___________ mg/kg (rounded to the nearest 100mg) in Normal Saline 250ml (Total Volume) over 2 hours for 1 year. Upon completion of Remicade treatment, infuse Normal Saline 20ml to clear line.

(Rheumatoid arthritis standard dose=3mg/kg. Crohn's disease/ulcerative colitis/ankylosing spondylitis/psoriatic arthritis/plaque psoriasis standard dose=5mg/kg

Premedication:Diphenhydramine 25mg p.o. 30 min. prior to infusion on all except first dose.

Last infusion date (if applicable):______________

FREQUENCY OF INFUSIONS:

☐ *RHEUMATOID ARTHRITIS/CROHN'S DISEASE/ULCERATIVE COLITIS/PSORIATIC ARTHRITIS/PLAQUE PSORIASIS :* 0, 2, 6 weeks, then every 8 weeks thereafter

☐ *ANKYLOSING SPONDYLITIS: 0, 2, 6 weeks, then every 6 weeks thereafter.*

OTHER: ____

LAB ORDERS:

☐ NONE ☐ CBC EVERY____________ ☐ OTHER:______________

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

Signature, prescribing MD _____________________________Date __________________