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REMICADE (INFLIXIMAB) INFUSION ORDERS

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
- TB & Hepatitis B documentation, CBC and Liver function should be followed at regular intervals
- TB Test Attached Perform TB Testing
- TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. Yearly TB Screening (*Optional*)
- Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- Crohn's Disease (ICD-10: _____)
- Ulcerative Colitis (ICD-10: _____)
- Rheumatoid Arthritis (ICD-10: _____)
- Ankylosing Spondylitis (ICD-10: _____)
- Psoriasis (ICD-10: _____)
- Other _____ (ICD-10: _____)

J Code: J1745

REMICADE ORDERS

Remicade Dose: _____ mg/kg Pt. Weight _____ kg

Frequency: Every _____ weeks or 0, 2, 6 then Every 8 weeks

Protocol Pre-Medication Orders: Tylenol 1000mg PO, *please choose one antihistamine:*

- Cetirizine 10mg PO
- Diphenhydramine 25mg PO
- Loratadine 10mg PO

Additional Pre-Medication Orders: Solu-Medrol _____ mg IV
 Solu-Cortef _____ mg IV

****Date of last** Orenzia Remicade Humira or Enbrel dose: _____ Date: _____

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	