# REMICADE (INFLIXIMAB)
# INFUSION ORDERS

****REQUIRD INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/progress notes, labs, tests supporting primary diagnosis
- ☐ TB 7 Hep B documentation, CBC< Liver function should be followed at regular intervals
- ☐ TB test protocol: Baseline testing: Quantiferon Gold or PPD.
  - ☐ TB test attached
  - ☐ Perform TB testing
- ☐ Yearly TB testing (optional)
- ☐ Hep B protocol: Hep B surface antigen & Hep B Core AB total required.

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|---|---|
| Patient Name: | DOB: |
| Allergies: | Patient Phone: |

**Diagnosis:**

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

**J Code: J1745**

**Remicade Orders**

**Remicade Dose**: _____mg/kg
**Frequency:** Every_____weeks or 0, 2, 6 then Every 8 weeks

**Protocol Pre-Medication Orders:** Tylenol 1000mg PO
Diphenhydramine 25 mg PO
**Additional Pre-Medication Orders:** Solu-Medrol _____ mg IV
**Date of last Remicade:___** or New Start

**Patient weight:** _____kg

| **Additional instructions:** |
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|---|---|
| **Physician Name:** | **Phone:**<br>**Fax:** |
| **Physician signature:** | **Date:** |