



## Community Health Interventions Specialty Clinic

### INFUSION ORDERS- REMICADE (INFLIXIMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
<input type="checkbox"/> Rheumatoid Arthritis	ICD 10 Code: M06.9
<input type="checkbox"/> Ankylosing Spondylitis	ICD 10 Code: M45.9
<input type="checkbox"/> Psoriatic Arthritis	ICD 10 Code: L40.52
<input type="checkbox"/> Plaque Psoriasis	ICD 10 Code: L40.0
Other: _____	ICD10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> TB Test Results
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Initial Dosing	<input type="checkbox"/> Remicade 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Remicade 5mg/kg IV every 8 weeks
Alternative Dosing	<input type="checkbox"/> Remicade _____ IV every _____ weeks
Patient Weight=	kg
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PREMEDICATIONS	
<input type="checkbox"/> Acetaminophen 650mg PO prior to Remicade infusion	
<input type="checkbox"/> Diphenhydramine 25mg PO prior to Remicade infusion	
<input type="checkbox"/> Methylprednisolone 40mg Slow IV Push PRN infusion reaction	
<input type="checkbox"/> Other:	

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PRESCRIBER INFORMATION		
Prescriber Name:		
		Office
Office Phone:	Office Fax:	Email:
Prescriber Signature:		Date:

**Contact us with questions at: [jeff@eastoninfusion.com](mailto:jeff@eastoninfusion.com) or call 728-777-5546**

Fax completed form and all documentation to **(561) 709-8626**

All information contained in this form is strictly confidential and will become part of the patient's medical record.