Remicade Infusion Orders

(infliximab)

Please fax the following documentation to 858 764-9765:

[ ]Demographics [ ]Insurance information [ ]H&P relevant to diagnosis [ ] Current TB/ Hep B /lab results
[ ]current medication and allergy list

Patient information:

Date: ___________________Patient Name/DOB____

ICD10 CODE______________________Diagnosis____

Weight_____________________lbs/kg Height_________________________________

Allergies____

Prescriber information:

Prescriber Name/NPI____

Office Address____

Contact Person_______________________Phone #___________________fax #___________________

Pre-Medications:

[ ] Acetaminophen 650mg PO [ ] Diphenhydramine 25mg [ ] Zyrtec/Claritin 10mg PO

Remicade (infliximab) IV Dosing total in mgs: _________________________

[ ] 3mg/kg [ ] 5mg/kg [ ] 7.5mg/kg [ ] 10mg/kg [ ] ok to round to nearest 100mg

Frequency:

[ ] initial dose at 0, 2, 6 weeks, **then** [ ] Q 4 weeks [ ] Q 6 weeks [ ] Q 8 weeks

Prescriber Signature____

PRN meds administered per San Diego Infusion Center Protocol

[ ] Diphenhydramine 50mg IV [ ] Solu-Medrol 125mg IV [ ] Normal Saline Bolus 500mls IV

Prescriber Signature_____________________________________