HEALTH CARE MEDICAL
Infusion Specialties
An Access Infusion Care Company

REMICADE (INFLIXIMAB) ORDERS

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address: _____	NPI: _____
City, State, Zip: _____	Street Address: _____
Cell: _____ Email _____	City, State, Zip: _____
Height ____ Weight ____ kg Last 4 of SSN: _____ DOB: _____	Phone: _____ Fax: _____
Allergies: _____	Contact Person: _____

REFERRAL STATUS	
☐ New Referral	First dose? ☐ Yes ☐ No - Date of last infusion: _____
☐ Dose or Frequency Change	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other
☐ Continuation Order	

DIAGNOSIS	
☐ Moderate to Severe Ulcerative Colitis ICD-10 CODE: _____	☐ Psoriatic Arthritis ICD-10 CODE: _____
☐ Moderate to Severe Crohn's Disease ICD-10 CODE: _____	☐ Plaque Psoriasis ICD-10 CODE: _____
☐ Rheumatoid Arthritis ICD-10 CODE: _____	☐ Other ICD-10 CODE: _____
☐ Ankylosing Spondylitis ICD-10 CODE: _____	

REQUIRED DOCUMENTATION	
• This signed order form by the provider	• Prior Therapies: _____
• Patient demographics and insurance information	• TB Screening ☐ Positive ☐ Negative Date: _____
• H&P, labs, tests, and progress notes supporting diagnosis	• Hepatitis Screening ☐ Positive ☐ Negative Date: _____

PRESCRIBING INFORMATION

Medication	Dose/Strength	Directions	Quantity
Infliximab Specific Brand (optional): _____	100 mg/ vial	Dilute in 0.9% NS for final concentration of 0.4 – 4 mg/ml over 2 hours Initiation ☐ Infuse ____mg/kg IV at week 0, 2, and 6 weeks.	Qty: sufficient for weight-based doses
		Maintenance ☐ Infuse ____mg/kg IV every 8 weeks ☐ Infuse ____mg/kg IV every ____ weeks	Qty: sufficient for weight-based doses per month Refill: ___

Use current documented weight; round calculated dose to nearest 100 mg and dispense sufficient 100 mg vials.
If no product is specified, an insurance-preferred biosimilar may be used.

PREMEDICATIONS (administer 30 minutes prior to infusion)

☐ Acetaminophen: ☐ 650 mg PO ☐ 1000 mg PO
☐ Diphenhydramine: ☐ 25 mg PO ☐ 50 mg PO ☐ 25 mg IV ☐ 50 mg IV
☐ Methylprednisolone: ☐ ____ mg IV ☐ 100 mg IV ☐ 125 mg IV
☐ Lab Work every _____ ☐ CMP ☐ CBC w dif ☐ CRP ☐ Sed Rate ☐ _____

PIV: Flush with 3–10 mL of 0.9% sodium chloride before and after the infusion PICC/Midline: Flush 10 mL 0.9% NS before/after, then 3 mL Heparin 10 units/mL final flush Port: Flush 10 mL 0.9% NS before/after, then 5 mL Heparin 100 units/mL final flush	RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline Post-Infusion: Use 50 ml 0.9% NS bag to flush residual priming volume

EMERGENCY MEDICATION

Administer the following medications as needed for infusion-related reactions per company protocol:

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Print, complete, and fax completed form to: (769) 233-8051

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Adults (>40 kg): Diphenhydramine 25–50 mg PO or IV slow push (2–5 min); Acetaminophen 325–650 mg PO; Methylprednisolone 125 mg IV slow push (≥5 min); Epinephrine 0.3 mg IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.
Pediatrics or Adults under (<40 kg): Diphenhydramine 25 mg PO or IV slow push (2–5 min); Acetaminophen 325 mg PO; Methylprednisolone 40 mg IV slow push (≥5 min); Epinephrine 0.15 mg (<30 kg) or 0.3 mg (>30 kg) IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.
Oxygen (AIC/AIS only): 1–6 L/min via NC or face mask; titrate to maintain SpO_2 95–100%.

Prescriber Signature X: _____ X: _____
Product Substitution Permitted: ____ Date: _____ Dispense as Written: ____ Date: _____

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