

REMICADE (INFLIXIMAB) IV INFUSION ORDER FORM

Full Name: Date of Birth:

Phone Number: Email Address:

Address:

Weight: lb/kg Allergies: ☐ NKDA ☐

Treatment Status: ☐ New ☐ Continued **Last Treatment Date:**

DIAGNOSIS (ICD-10 SELECTION)

☐ K50.90 – Crohn's disease, unspecified ☐ L40.52 – Psoriatic arthritis

☐ K51.90 – Ulcerative colitis, unspecified ☐ L40.0 – Plaque psoriasis

☐ M06.9 – Rheumatoid arthritis, unspecified ☐ ICD-10 CODE:

☐ Other:

INFUSION ORDER

Induction Phase:

☐ 5 mg/kg IV at Weeks 0, 2, and 6

Maintenance Phase:

☐ 5 mg/kg IV every 8 weeks

☐ Alternative: mg/kg IV every weeks

☐ Infuse over ≥ 2 hours (may reduce to 1 hour if tolerated)

☐ Use 0.2-micron low-protein binding in-line filter

☐ Observation: ☐ 30 minutes post-infusion

☐ Refills: ☐ None ☐ 6 months ☐ 12 months ☐ Other:

LINE USE & ACCESS

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☒ Flush per standard injection protocol

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☒ Kaison Infusion Center Protocol (www.kaisoninfusion.com)

☐ Other - please fax preferred reaction orders to (405) 237-6305

PREMEDICATION (OPTIONAL)

☐ Acetaminophen: ☐ 650 mg ☐ PO

☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV

☐ Methylprednisolone: ☐ 125 mg ☐ IV

☐ Cetirizine: ☐ 10 mg ☐ PO

☐ Other: Dose: Route:

LABORATORY MONITORING

☐ CBC ☐ CMP ☐ CRP ☐ CSR ☐ TB Screening ☐ Hepatitis B Panel ☐ Other:

Frequency: ☐ Prior to first dose ☐ Every infusion ☐ Monthly ☐ Other:

☐ Physician office will order labs only

CLINICAL DOCUMENTATION CHECKLIST

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

☐ Documentation of prior DMARD or biologic therapy

ORDERING PROVIDER & DEMOGRAPHICS

Name: NPI: LICENSE #:

Contact: Phone: Fax:

Email: Signature: Date: