

Patient Information

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):			_____
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
Does the patient need interpreter services:		Yes	No

Provider Information

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip:

ICD-10 CODE

K50.90 Crohn's/Pediatric Crohn's Disease	L40.50 Psoriatic Arthritis
K51.90 Ulcerative Colitis/Pediatric UC	L40.0 Plaque Psoriasis
M06.9 Rheumatoid arthritis	Other: _____
M45.9 Ankylosing Spondylitis	

Medication Order

Remicade (infliximab)	Preferred Agent (only select one)	Use if preferred agent is not covered by the patients insurance
Avsola (infliximab-axxq)	Preferred Agent (only select one)	Use if preferred agent is not covered by the patients insurance

Dose:	Frequency:
3mg/kg (____mg) IV	Other: _____
5mg/kg (____mg) IV	Initiation therapy: 0, 2 and 6 weeks then every 8 weeks Qty: 3 doses
7.5mg/kg (____mg) IV	Initiation therapy: 0, 2 and 6 weeks then every 6 weeks Qty: 3 doses
10mg/kg (____mg) IV	Initiation therapy: 0, 2 and 6 weeks then every _____weeks Qty: 3 doses
	Maintenance therapy: Every 8 weeks Qty:1 dose
	Maintenance therapy: Every 6 weeks Qty:1 dose
	Maintenance therapy: Every _____weeks Qty:1 dose

Note: Pharmacist will calculate infusion rates unless otherwise specified: _____

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (Negative Hep B and TB)	Insurance Card (front and back)	Current Medications	History/Progress Notes
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Pre-Medication Order

acetaminophen (Tylenol)	500mg	650mg	1000mg PO	diphenhydramine (Benadryl)	25mg	50mg /	PO	IV
cetirizine (Zyrtec)	10mg PO			methylprednisolone (Solu-Medrol)	40mg IV		125mg IV	
loratadine (Claritin)	10mg PO			hydrocortisone (Solu-Cortef)	100mg IV			
Other: _____								
Dose: _____			Route: _____			Frequency: _____		

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

Do NOT administer heparin to this patient

Additional orders: _____

Adverse Reaction and Anaphylaxis Orders

Standard anaphylaxis kit (epinephrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses;
Benadryl 50 mg PO PRN for mild-moderate reactions x 1; Benadryl 50 mg IV PRN for mild-moderate reactions x 1)

Additional orders: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name

Provider Signature

Date

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order