

(infliximab)

# REMICADE infusion orders



Patient Name

DOB

Phone

M

F

## DIAGNOSIS Please provide ICD-10 code

Rheumatoid Arthritis

Crohn's Disease

Psoriatic Arthritis

Ulcerative Colitis

Plaque Psoriasis

Ankylosing Spondylitis

## PRE-MEDICATION

Tylenol 1000mg PO

Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO

Solu-Cortef 100mg IVP

Cetirizine 10mg PO

Diphenhydramine 25mg IVP

## REMICADE ORDERS

DOSAGE		PATIENT WEIGHT
mg/kg	<i>weight-based</i>	lbs.
mg	<i>flat-dosed</i>	kg
FREQUENCY		
every 0,2,6, and every 8 weeks	<i>(induction)</i>	
every	weeks	

## NOTES

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date

Provider

Phone

Fax