RED RIVER HEALTH
Ambulatory Infusion Clinic

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# **REMICADE** (infliximab – inflectra – renflexis – avsola) Infusion Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

**Diagnosis** *(please provide ICD-10 code)*:

☐ _____ Rheumatoid Arthritis (RA)

☐ _____ Crohn's Disease (CD)

☐ _____ Ulcerative Colitis (UC)

☐ _____ _____ *(other)*

**Pre-Medication:**

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO

☐ Other: _____

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

**Required Documents:**

☑ Patient Demographic Sheet

☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*

☑ TB Status & Date *(please attach results)*

☑ HepB Status & Date *(please attach results)*

## MEDICATION ORDERS:

☐ Infuse Remicade -OR- ☐ Infuse biosimilar as required by patient's insurance

**based on product availability and patient insurance requirements, product recommendations may be provided*

**Dosing:** ☑ Mix in 250ml 0.9% sodium chloride, administer IV over at least 2 hours

☐ _____mg/kg *(weight based)* **Pt. weight:** _____ *(ensure unit of measure is noted)*

☐ _____mg *(flat-dosed)*

**Frequency:** ☐ Every 0, 2, 6, and every 8 weeks *(induction)* ☐ Other: _____

☐ Every _____ weeks *(maintenance)*

**Refills:** _____ *(if not indicated, Rx will expire one year from date signed)*

## Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____