MEDICATION ORDERS

REMICADE (INFLIXIMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE

☐ Ankylosing Spondylitis	ICD 10 Code: M45.9	☐ Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90	☐ Rheumatoid Arthritis	ICD 10 Code: M06.9
☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90	☐ Other:_____	ICD10 Code: _____
☐ Plaque Psoriasis	ICD 10 Code: L40.0		

REQUIRED DOCUMENTATION/TESTING

☐ This signed order form by the provider	☐ Confirmed negative TB QuantiFERON Gold to include Interferon Gamma Assay results
☐ Patient demographics AND insurance information	
☐ Clinical/Progress notes supporting diagnosis	☐ CMP and Bilirubin lab results

List Tried and Failed Therapies, including duration of treatment:

1)

2)

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Initial Dosing: ☐ Remicade 5mg/kg IVPB over at least two hours at week 0, 2, 6, then every 8 weeks thereafter

Maintenance Dosing: ☐ Remicade 5mg/kg IVPB over at least two hours every 8 weeks

Alternative Dosing: ☐ Remicade_____ IV every_____ weeks

Refills: ☐ x 6 months ☐ x 1 year ☐ _____ doses

Treatment Labs:

- ✓ Pregnancy test within 72 hours prior to initiation of therapy for female patient under 55 years of age and no history of surgical hysterectomy.
- ✓ TB QuantiFERON Gold (if not provided by referral provider)
- ☐ No additional pre-treatment lab test required at the infusion site. Routine lab monitoring required by the FDA will be assessed and managed by the referring provider.
- ☐ Other Labs and Frequency: _____

- New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.
- Please note for patients receiving treatment at the Montgomery Cancer Center: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.
- Please note for patient receiving treatment at Baptist East Outpatient Infusion: if an infusion reaction occurs, the Baptist East staff will follow the PRN hypersensitivity standing orders and will contact the referring provider in the event of an emergency. For life threatening anaphylaxis, Baptist East staff will follow rapid response policy or 911 facility policy.

PREMEDICATIONS

- ✓ Acetaminophen 1000mg PO prior to Remicade infusion
- ✓ Diphenhydramine 25mg IVP prior to Remicade infusion
- ☐ Other: _____

OTHER ORDERS

Hold treatment if the patient has any infections prior to infusion.

Physician Signature: Date:

Patient Name: _____ Date of Birth: _____

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All order sets will include a statement to activate these PRN hypersensitivity standing orders when necessary.

REACTION SYMPTOMS		DRUG	DOSE	ROUTE
Fever, chills and or rigors	✓	Acetaminophen (Tylenol)	1000mg	PO
Itching, facial flushing, hives, rash	✓	Diphenhydramine (Benadryl)	50mg	IVP
	✓	Famotidine (Pepcid)	20mg	IVP
	✓	Methylprednisolone (Solu-Medrol)	125mg	IVP
Hypotension, wheezing, shortness of breath, facial/lip/tongue swelling	✓	Normal Saline	150ml/hr	IV
	✓	Diphenhydramine (Benadryl)	50mg	IVP
	✓	Methylprednisolone (Solu-Medrol)	125mg	IVP
	✓	Hydrocortisone (Solu-Cortef)	50mg	IVP
	✓	Epinephrine Pen	0.3mg	IM
Nausea/Vomiting	✓	Granisetron (Kytril)	1mg	IVP

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

For questions, please contact
Baptist Outpatient Infusion Services @ (334) 747-7401

Fax completed form and all documentation to
Baptist Outpatient Infusion Services @ (334) 747-7403