Infliximab (Remicade)

Provider Order Form

Newport Superior Infusion
1501 Superior Ave, Suite 202
Newport Beach, CA 92663
Phone: 949-601-6001
Fax: 866-542-8631

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs / kg: Height in / cm:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☐ Provide nursing care per Newport Infusion Standard Procedures

☐ Hepatitis B status and date (list results and attach clinicals): _____

RECOMMENDED PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) 125mg IV

PRE-MEDICATION ORDERS

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20mg PO

☐ Other: _____

Dose: _____ Route: _____

Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

THERAPY ADMINISTRATION

☑ **Infliximab** (Remicade) 100mg Vials in 250mL 0.9% NaCl intravenous infusion

- Dose
  - ☐ Induction: Infuse 5mg/kg at week 0, 2, 6 and every 8 weeks thereafter
  - ☐ Maintenance: Infuse 5mg/kg every 8 weeks
  - ☐ Other: _____
- Rate
  - ☐ Initiate infusion at 10mL/hr. If tolerated, may increase by 10mL/hr at 15 minute interval to max of 125mL/hr
  - ☐ Other: _____
- Quantity: _____ # of Vials

Refills: ☐ Zero / ☐ for 12 months
☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Date**

Provider Signature