5115 80th Street, Lubbock, TX 79424

Tel (806) 788-4368, Fax (806) 302-1241

REMICADE (inflixinab) Infusion orders

Name:_____ DOB:_____ M ○ F ○

Phone #1 :_____(H/W/C) Phone :_____(H/W/C)

Diagnosis: Please provide ICD-10 code

○_____ Crohn's Disease ○_____ Ulcerative Colitis
○_____(other)

Pre Medication:

☐ Tylenol 1000 mg PO
☐ Diphenhydramine 25 mg PO
☐ Diphenhydramine 25 IVP
☐ Solu-Medrol 150mg IVP
☐ Solu-Medrol 100mg IVP
☐ _____(other)

REMICADE ORDERS
DOSAGE/ Frequency

PATIENT WEIGHT
_____lbs
_____kg

☐ _____mg/kg weight base
☐ _____mg flat dosed
☐ Every 0, 2, 6 and every 8 weeks after (induction)
☐ Dose every _____ weeks ☐ _____(other)
☐ Check hepatitis B antibodies and T spot once a year per infusion protocol.

Needed documents:

☐ Recent Office notes (along with any therapies tried and outcomes)
☐ Current Medication List History, ☐ Physical Report (w/in past 6 months)
☐ Lab Results, ☐ Demographic Sheet, ☐ Insurance Cards (front and back)

ORDERING PROVIDER

Signature_____ Date_____

Provider _____ Phone_____ Fax_____

Please **FAX** form and documents needed to **1-806-302-1241 (dial "1")**