

PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name: _____		Prescriber Name: _____	
Address: _____		NPI: _____	
City, State, Zip: _____		Street Address: _____	
Cell: _____ Email: _____		City, State, Zip: _____	
Height _____ Weight _____ kg Last 4 of SSN: _____ DOB: _____		Phone: _____ Fax: _____	
Allergies: _____		Contact Person: _____	

REFERRAL STATUS	
☐ New Referral	First dose? ☐ Yes ☐ No - Date of last infusion: _____
☐ Dose or Frequency Change	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other
☐ Continuation Order	

DIAGNOSIS	
☐ Moderate to Severe Ulcerative Colitis ICD-10 CODE: _____	☐ Psoriatic Arthritis ICD-10 CODE: _____
☐ Moderate to Severe Crohn's Disease ICD-10 CODE: _____	☐ Plaque Psoriasis ICD-10 CODE: _____
☐ Rheumatoid Arthritis ICD-10 CODE: _____	☐ Other ICD-10 CODE: _____
☐ Ankylosing Spondylitis ICD-10 CODE: _____	

REQUIRED DOCUMENTATION	
- This signed order form by the provider - Patient demographics and insurance information - H&P, labs, tests, and progress notes supporting diagnosis	- Prior Therapies: _____ - TB Screening ☐ Positive ☐ Negative Date: _____ - Hepatitis Screening ☐ Positive ☐ Negative Date: _____

PRESCRIBING INFORMATION			
Medication	Dose/Strength	Directions	Quantity
Infliximab Specific Brand (optional): _____	100 mg/ vial	Dilute in 0.9% NS for final concentration of 0.4 – 4 mg/ml over 2 hours Initiation ☐ Infuse ____ mg/kg IV at week 0, 2, and 6 weeks. Maintenance ☐ Infuse ____ mg/kg IV every 8 weeks ☐ Infuse ____ mg/kg IV every ____ weeks	Qty: sufficient for weight-based doses Qty: sufficient for weight-based doses per month Refill: ____
Use current documented weight; round calculated dose to nearest 100 mg and dispense sufficient 100 mg vials. If no product is specified, an insurance-preferred biosimilar may be used.			
PREMEDICATIONS (administer 30 minutes prior to infusion) ☐ Acetaminophen: ☐ 650 mg PO ☐ 1000 mg PO ☐ Diphenhydramine: ☐ 25 mg PO ☐ 50 mg PO ☐ 25 mg IV ☐ 50 mg IV ☐ Methylprednisolone: ☐ ____ mg IV ☐ 100 mg IV ☐ 125 mg IV ☐ Lab Work every _____ ☐ CMP ☐ CBC w dif ☐ CRP ☐ Sed Rate ☐ _____			
PIV: Flush with 3–10 mL of 0.9% sodium chloride before and after the infusion PICC/Midline: Flush 10 mL 0.9% NS before/after, then 3 mL Heparin 10 units/mL final flush Port: Flush 10 mL 0.9% NS before/after, then 5 mL Heparin 100 units/mL final flush		RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline Post-Infusion: Use 50 mL 0.9% NS bag to flush residual priming volume	

EMERGENCY MEDICATION

Administer the following medications as needed for infusion-related reactions per company protocol:

REMICADE (INFLIXIMAB) ORDERS

Adults (>40 kg): Diphenhydramine 25–50 mg PO or IV slow push (2–5 min); Acetaminophen 325–650 mg PO; Methylprednisolone 125 mg IV slow push (≥5 min); Epinephrine 0.3 mg IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.

Pediatrics or Adults under (<40 kg): Diphenhydramine 25 mg PO or IV slow push (2–5 min); Acetaminophen 325 mg PO; Methylprednisolone 40 mg IV slow push (≥5 min); Epinephrine 0.15 mg (<30 kg) or 0.3 mg (>30 kg) IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.

Oxygen (AIC/AIS only): 1–6 L/min via NC or face mask; titrate to maintain SpO₂ 95–100%.

Prescriber Signature X: _____ X: _____

Product Substitution Permitted: _____ Date: _____ Dispense as Written: _____ Date: _____