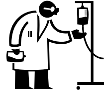

Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

REMICADE IV Infusion ORDER

**Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: _______________________________ **Patient Weight:** _________lbs / kg **Height:**_________

Diagnosis:____

DX CODES: ***ICD-10*** **:** ________________________, ________________________, ______________________

TB verification ***(circle one):*** **TB skin test** **TB spot/Quantiferon blood test** **Chest X-RAY**
☐ **COPY ATTACHED**

Result Date: ________/_______/___________ Result ***(circle one):*** **Positive** **Negative**

LABS to be drawn: ☐ **CBC** ☐ Other: ___________________________________
Lab Frequency**:** ______________________

Pre- Medications:

Diphenhydramine PO or IV	25mg or 50mg	☐Yes	☐ No
Cetirizine PO	10mg	☐Yes	☐ No
Acetaminophen PO	650mg	☐Yes	☐ No
Solu-Medrol IV	________mg	☐Yes	☐ No

Start Date of Infusion: _____/_____/_____ **Remicade Infusion #** ____________ ☐ **Continuation of treatment**

Remicade IV Dosage: ☐ **3mg/kg** ☐ **5mg/kg** ☐ **7.5 mg/kg** ☐ **10mg/kg** ☐ **Other:** ________

WHEN CALCULATING DOSE:

☐ **ROUND to nearest vial (100 mg per vial)**
☐ **ROUND to the nearest half vial (50 mg increment)**
☐ **Dose:**________________________

Frequency: ☐ **Initial Dose – 0, 2, 6wks, then either** ☐ **q 6 wks or** ☐ **q 8 wks** ☐ **Other:** _______

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: ____

Provider Signature: ____

Office Phone Number: _______________________**Office Fax Number:** __________________________________