CIVIC INFUSION CENTER

(infliximab)

REMICADE infusion orders

Patient Name

DOB

Phone

M F

DIAGNOSIS *Please provide ICD-10 code*

Rheumatoid Arthritis
Psoriatic Arthritis
Plaque Psoriasis
Ankylosing Spondylitis
Crohn's Disease
Ulcerative Colitis

PRE-MEDICATION

Tylenol 1000mg PO
Diphenhydramine 25mg PO
Cetirizine 10mg PO
Solu-Medrol 125mg IVP
Solu-Cortef 100mg IVP
Diphenhydramine 25mg IVP

REMICADE ORDERS

DOSAGE

mg/kg *weight-based*

mg *flat-dosed*

PATIENT WEIGHT

lbs.

kg

FREQUENCY

every 0,2,6, and every 8 weeks *(induction)*

every weeks

NOTES

ORDERING PROVIDER

Signature **X** ____________________ Date

Provider Phone Fax

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