Comanche County Memorial Hospital

Remicade/Inflectra Order Form

Phone: 580-250-5899 | Fax: 580-585-5472

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

HT: _____ WT: _____ DOB: _____ Sex: ( ) Male ( ) Female SSN: _____

Street Address _____ City/Stale/Zip _____

Home Phone # _____ Work # _____ Cell # _____

Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID# _____

Secondary Insurance Name _____ Policy ID# _____

PHYSICIAN/FACILITY INFORMATION

Physician's Name _____ Contact Name _____

Contact Phone # _____ Fax #: _____

Address _____ City/State/Zip _____

DEA# _____ NPI# _____ State License # _____

REQUIRED STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis (ICD 10 code ***AND*** CPT code) _____

Secondary Diagnosis (ICD 10 code ***AND*** CPT code) _____

PRESCRIPTION ORDERS: REMICADE OR INFLECTRA

All doses will be rounded to the nearest 100 mg vial

All mediports/ports/VAD will be flushed with Heparin per hospital protocol

50 mL bag of normal saline will be hung to clear all patient lines

☐ Initial dose: _____ mg/kg IV on day 0, 2 weeks, 6 weeks, and then every _____ weeks

☐ Maintenance dose: _____ mg/kg IV every _____ weeks

PRE-MEDICATIONS:

Benadryl PRN: _____ mg ☐ PO ☐ IV ☐ IVP Other: _____

Acetaminophen PRN: _____ mg ☐ PO ☐ IV ☐ IVP Oxygen: _____

FLUSHES:

☑ **Heparin 500 units/5 mL Flush Syringe PRN**

☑ **10 mL Normal Saline flush syringe PRN**

☑ **50 mL Normal Saline PRN**

☑ **250 mL Normal Saline PRN**

NOTES: _____

Physician's Signature _____ Date & Time: _____