Comanche County Memorial Hospital

Outpatient Infusion Center
Remicade/Inflectra Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: M F

Patient Address: Email: Insurance:

Additional Information Needed

- ☐ Fax front/back of insurance card
- ☐ Fax patient demographics
- ☐ Fax clinical/progress notes
- ☐ Fax current medication list
- ☐ Fax labs
- ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

- ☐ K50.90 Crohn's Disease, Unspecified, without complications
- ☐ K51.90 Ulcerative Colitis, Unspecified, without complications
- ☐ L40.0 Psoriasis Vulgaris (moderate-to-severe plaque psoriasis)
- ☐ L40.52 Psoriatic Arthritis Multilans
- ☐ L40.59 Other Psoriatic Arthropathy
- ☐ M06.9 Rheumatoid Arthritis, Unspecified
- ☐ M09.09 Rheumatoid Arthritis without Rheumatoid Factor, Multiple Sites
- ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
- ☐ M45.9 Ankylosing Spondylitis of Unspecified Sites in Spine
- ☐ Other: DX: _____

Clinical Information:

- ☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
- ☐ Patient Weight: _____ lbs/ _____ kg ☐ Patient Height: _____ in/ _____ cm
- ☐ Allergies: _____
- ☐ Therapies Tried and Failed: _____
- ☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____
- ☐ Does the patient have venous access? Yes or No If yes, What type? _____

If No, initiate IV access.

Lab Orders

- ☐ CBC w/o diff ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold
- ☐ Other: _____

Lab Orders to be done by

- ☐ Infusion Services
- ☐ Referring Provider

Prescription Information

☐ Remicade	☐ Initial Dose: _____mg/kg IV Beginning week, week 2 and week 6 ☐ Maintenance Dose: _____mg/kg IV every _____ weeks after week 6
☐ Inflectra	☐ Initial Dose: _____mg/kg IV Beginning week, week 2 and week 6 ☐ Maintenance Dose: _____mg/kg IV every _____ weeks after week 6

Misc Orders

- ☐ _____
- ☐ _____
- ☑ PICC/Midline/CAD dressing to be changed every 7 days

Flushes

- ☑ 10mL NS Flush Syringe PRN
- ☑ Heparin 500units/5mL Flush Syringe PRN
- ☑ 50ml NS Bag PRN
- ☑ 250ml NS Bag PRN

Standing Orders for Adverse Reaction

- ☑ Stop infusion and initiate NS bolus
- ☑ Notify Supervising physician and ordering provider
- ☑ Solu-Cortef 100mg SIVP signs of adverse reaction
- ☑ Benadryl 25 mg SIVP for hives or bronchial inflammation
- ☑ Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
- ☑ Oxygen 2-5L nasal cannula
- ☑ Albuterol 2.5mg inhaled PRN to chest tightness
- ☐ Other: _____

Prescriber Information

Physician Name: _____ Official Contact Name: _____

Contact #: _____ Fax Number: _____

Address: _____ City/State/Zip: _____

NPI#: _____ DEA#: _____ State License #: _____

_____ _____

Physician's Signature Date Time