

Infliximab (Remicade, Renflexis, Avsola) Infusion OrdersPatient Name: _____ DOB: _____ ☐ Male ☐ FemaleDiagnosis (please provide ICD10 code): ☐ Ulcerative Colitis ☐ Crohn's Disease☐ Rheumatoid Arthritis ☐ Other: _____☐ NKDA Allergies: _____☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____**Ordering Provider:**

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

PRE-MEDICATION

- ☐ Acetaminophen 1000mg PO ☐ Solu-Medrol 125mg IVP
☐ Diphenhydramine 25mg PO ☐ Solu-Cortef 100mg IVP
☐ Ceterizine 10mg PO ☐ Diphenhydramine 25mg IVP

REQUIRED LABS

- ☒ TB status and date (please attach results):

☒ Hepatitis B status & date (please attach results):

INFLIXIMAB ORDERS

- ☐ Infuse Remicade -OR- ☐ Infliximab Biosimilar as required by patient's insurance

Based on product availability and patient insurance requirements, product recommendations may be provided

DOSING:

- ☒ Mix in 250ml 0.9% sodium chloride, intravenous infusion over at least 2 hours
Dose: ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ Other: _____ Pt weight: _____

FREQUENCY:

- ☐ Dose at weeks 0, 2, and 6, then every 8 weeks
☐ Maintenance dose every _____ weeks
☐ Other: _____

REFILLS:

- ☐ _____
(if not indicated prescription will expire one year from date signed)

Noble Infusion Standing Orders:

- ☒ Provide treatment under Noble Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name_____
Provider Signature_____
Date