3-Hole 1/4 1 3/8 c-to-c

INFLIXIMAB (REMICADE) ORDER SHEET

Orders Provider

Please mark appropriate boxes, No Orders Will Be Activated If Not Clearly Indicated

Diagnosis: _____

Allergies: _____

***Ht** _____ **inches**
***Wt** _____ **lbs**
***M²** _____

Laboratory Testing: (to be performed with each Remicade administration)

❑ CBC-D ❑ CMP ❑ ESR ❑ C-RP
❑ Other: _____

Pre-Medication Orders: Circle Dosage & Route of Administration

❑ Acetaminophen [TYLENOL]	650 mg	1000 mg	P.O.
❑ Diphenhydramine [BENADRYL]	25 mg	50 mg	P.O. **or** IVP (either unless specified)
❑ Cimetidine [TAGAMET]	400 mg	_____ mg	P.O.
❑ Fexofenadine [ALLEGRA]	180 mg	_____ mg	P.O.

Note: Do not give Allegra™ if patient is pregnant and less than 12 weeks gestation

❑ No Pre-Medications

Remicade dose: _____ mg or _____ mg/kg (3-10 mg/kg)

Frequency:

❑ Std Starting Regimen: Initial dose; 2nd dose at 2 weeks from initial dose; 3rd dose 6 weeks from initial dose & then every 8 weeks until changed or canceled.
❑ Patient has already completed starting regimen, give _____ mg every _____ weeks

Administration

❑ **Follow Current Protocol** (Manufacturers Guidelines)
Titration from 10 ml/hr → 250 ml/hr over 75 min (total infusion time 2hr)
❑ **Other:** _____

Required Entry: (Check One)

❑ Call me for management of Medication Reactions (M.D. Phone Number): _____

OR

❑ Have Infusion Center Physician manage any medication reactions, including PRN medications

Signature: _____
Printed Name/ID#: _____
Date: _____ Time: _____

Renewals or changes:

_____ Signature: _____ Date: _____ Time: _____
_____ Signature: _____ Date: _____ Time: _____
_____ Signature: _____ Date: _____ Time: _____
_____ Signature: _____ Date: _____ Time: _____

PATIENT IDENTIFICATION

PRESBYTERIAN
Presbyterian Infusion Center
Tele: (505) 563-1309
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