Fountains
Infusion Center

159 Fountains Blvd.
Madison, MS 39110
Phone: 601.859.8200
Fax: 601.859.8201

REMICADE (INFLIXIMAB)
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
☐ TB & Hepatitis B documentation, CBC and Liver function should be followed at regular intervals
☐ TB Test Attached ☐ Perform TB Testing
☐ **TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*
☐ **Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Crohn's Disease (ICD-10: _____) ☐ Ulcerative Colitis (ICD-10: _____)
☐ Rheumatoid Arthritis (ICD-10: _____) ☐ Ankylosing Spondylitis (ICD-10: _____)
☐ Psoriasis (ICD-10: _____) ☐ Other_____ (ICD-10: _____)

J Code: J1745

REMICADE ORDERS

Remicade Dose: _____mg/kg Pt. Weight _____ kg

Frequency: Every_____weeks or ☐ 0, 2, 6 then Every 8 weeks

Protocol Pre-Medication Orders: Tylenol 1000mg PO, *please choose one antihistamine:*
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IV
☐ Solu-Cortef _____ mg IV

****Date of last** ☐ Orencia ☐ Remicade ☐ Humira or ☐ Enbrel dose:_____ ☐ Date:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	