

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: ____/____/____ Male Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____ NPI: _____

ALLERGIES / REACTIONS

Signature: _____

Date: _____

PHYSICIAN ORDERS

HUMIRA (Citrata Free)

REFILLS: _____

Crohn's /UC Starter Kit – Induction Dose

DAY 1 – HUMIRA 2 x 80mg/0.8ml (160 mg) – SQ

DAY 15 – HUMIRA 80 mg/0.8 ml – SQ

Crohn's /UC – Maintenance Dose

Day 29 – HUMIRA 40 mg/0.4ml – SQ

Then HUMIRA 40 mg/0.4ml – SQ every other week

Crohn's /UC Other Dosing

Humira _____ mg SQ – every _____ week(s)

Anaphylaxis Kit per Pharmacy protocol

TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER PRN FOR PATIENTS RECEIVING IV MEDS IN THE HOME

Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

ADVERSE REACTION ORDERS:

Mild Reactions - Reduce rate by 1/2 at time of onset and keep reduced x30 minutes. If resolved, increase per guidelines. If not resolved, administer appropriate medication based on symptoms,

Severe Reactions - STOP infusion , KVO IV Normal Saline Diphenhydramine 25/50 mg IVP over 3-5 minutes

Methylprednisolone 125 mg IVP over 5 minutes Call Ambulance and Physician .

DIAGNOSIS:

K50.90 Crohn's Disease NOS K51.90 Ulcerative Colitis Other: _____