

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

REMICADE **INFLECTRA** **INFLIXIMAB** **REFILLS:** _____

- Initial Dose: Infuse _____ mg/kg (____mg) IV at 0, 2, & 6 weeks
 Maintenance: Infuse _____ mg/kg (____mg) IV every _____ weeks

IV ACCESS

- Peripheral IV - Flush with Normal Saline 5-10 ml with IV start and before & after medication
 Subcutaneous Port - Flush with Normal Saline 10 ml before & after medication---LOCK with Heparin 500 units (100 units/ml)

PRE-MEDICATIONS / LABS **REFILLS:** _____

- Diphenhydramine _____ MG IV 30 minutes before infusion Solu-Medrol _____ MG IV 30 minutes before infusion
 OTHER: _____
 LABS: _____ FREQUENCY _____

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:

- M06.9 Rheumatoid Arthritis M08.0 Juvenile Rheumatoid Arthritis L40.50 Psoriatic Arthritis
 M45.9 Ankylosing Spondylitis Other: _____