Lincoln Medical Center
OUTPATIENT INFUSION CENTER
Phone: 931-438-1100
Fax: 1-931-438-1219

INFLIXIMAB ORDER FORM

Patient name: _____ DOB: _____ Sex :( ) Male ( ) Female

SSN:_____ HT: _____ WT: _____ Allergies:_____

Street Address_____ City/State/Zip _____

Home Phone #: _____ Work #: _____ Cell #: _____

Insurance Information:

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Information:

Physician's Name:_____ Referral Contact Name: _____ Phone: _____

Address:_____City/State/Zip_____

DEA#:_____ NPI #:_____ Fax #: _____

State License #: _____

Statement of Medical Necessity

Primary Diagnosis: (ICD-10 Code plus Description)_____Date of Diagnosis: _____

Pertinent Medical History

TB test performed: ☐ Yes ☐ No Results: _____

Congestive Heart Failure diagnosis: ☐ Yes ☐ No Liver function test normal: ☐ Yes ☐ No

Previously treated with Remicade: ☐Yes ☐ No Date of last treatment: _____

Previous Hep-B antigen surface antibody test: ☐ Yes ☐ No Date of test: _____

Orders: REMICADE® (INFLIXIMAB) **** All doses will be rounded to the nearest 100mg ****

***Normal Saline will be used to clear all lines. All MEDIPORTS/PORTS/VAD will be flushed with Heparin and Saline per hospital protocol. ***

☐ Do not administer Heparin to this patient. ☐ Insert PIV ☐ Insert PICC

Dose:

- ☐ 5mg/kg IV in NS 0.9% 250ml over not less than 2 hours with 1.2 micron filter
- ☐ 10mg/kg IV in NS 0.9% 250ml over not less than 2 hours with 1.2 micron filter
- ☐ _____mg IV in NS 0.9% 250ml over not less than 2 hours with 1.2 micron filter

Frequency:

- ☐ Loading doses: Infusion at 0, 2, and 6 weeks, then once every _____ weeks
- ☐ Once every _____weeks

Lab: CMP at every infusion

Premedication:

☐ Benadryl: _____mg ☐ PO ☐ IV X1 dose

☐ Oxygen: _____

Other:_____

For Infusion Reaction: Slow / temporarily stop infusion. Upon resolution, resume infusion at decreased rate as tolerated. If not tolerated, stop infusion and notify provider. If severe hypersensitivity reaction occurs, have acetaminophen, antihistamines, corticosteroids, and epinephrine available.

Physician's Signature _____**Date**_____ **Time:**_____

Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.