

Edward-Elmhurst Cancer Centers

120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Remicade (Infliximab) Infusion Therapy Orders

Patient Name: _____ DOB: _____

Weight: _____ Height: _____ Allergies: _____

Please include current history and physician and any recent labs/tests, if applicable

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Required information (anything left unanswered may result in a delay in treatment)	
Pre-Authorization # or Call Reference #	
Does insurance require medication to be provided by specialty pharmacy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please provide pharmacy name and contact number _____
Diagnosis and ICD 10 Code	
Annual TB test date/Was TB test negative	Date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No

Dosage Information (will be dispensed in appropriate volume, and administer per product instructions)	
Is this a first dose	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dosing Guideline	Rheumatoid Arthritis initial dose 3 mg/kg Adult Crohn's or Fistulating Crohn's Disease initial dose 5 mg/kg Ankylosing Spondylitis initial dose 5 mg/kg Psoriatic Arthritis initial dose 5 mg/kg Plaque Psoriasis initial dose 5 mg/kg (All doses may be titrated up to 10 mg/kg)
Dose (weight based and total dose)	<input type="checkbox"/> 3mg/kg = _____ mg <input type="checkbox"/> 5 mg/kg _____ mg <input type="checkbox"/> 10 mg/kg= _____ mg <input type="checkbox"/> _____ mg/kg = _____ mg (note doses will be rounded to nearest 100mg)
Dosing Frequency	<input type="checkbox"/> At weeks 0, 2, 6, and then every 8 weeks <input type="checkbox"/> Every 8 weeks <input type="checkbox"/> Every _____ weeks
Expiration of Prescription	<input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other

Pre-Medications: (Please mark all that apply)

- Tylenol 650mg po prior to infusion
- Benadryl 25mg IV prior to infusion
- Benadryl 25mg po prior to infusion

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated provider will evaluate your patient and your office will receive notification of the event.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Monitoring: Monitor vital signs pre- and post-infusion or as clinically indicated.

Physician Signature: _____ **Date:** _____

Physician Name: _____

Office Phone Number: _____

Ordering Physician NPI: _____

Edward Hospital NPI: 1427069632

Office Fax: _____

Elmhurst Hospital NPI: 1548306343