MATAGORDA REGIONAL
MEDICAL CENTER
MRMC IV THERAPY SERVICES
PHONE: 979-241-5966
FAX: 979-241-5965

REMICADE ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ WT: _____ Sex :( ) Male ( ) Female SSN:_____ Home #:_____ Cell#:_____

Street Address_____ City/State/Zip _____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

PHYSICIAN / FACILITY INFORMATION

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

DEA#:_____ NPI #:_____ State Lic #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY ICD-10 Code plus Description

_____

PERTINENT MEDICAL HISTORY **1)** TB test performed? O Yes O No Results,_____

2) Patient diagnosed with Congestive Heart Failure? O Yes O No **3)** Liver function test normal? O Yes O No

4) Patient previously treated with Remicade? O Yes O No Date: _____ 5) Hep-B antigen surface antibody test? O Yes O No Date: _____

a) ALL IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
b) INFLIXIMAB WILL BE ADMINISTERED IN NS 0.9% 250 ML OVER NO LESS THAN 2 HOURS WITH A 1.2 MICRON FLITER
c) ADMINISTER CATH-FLO 2MG, IVP IF PICC LINE BECOMES SLUGGISH OR OCCLUDED; MAY REPEAT AFTER 2 HRS IF NEEDED X1

PRESCRIPTION ORDERS: REMICADE® (INFLIXIMAB) ALL DOSES WILL BE ROUNDED TO NEAREST 100MG

Does patient have venous access? ☐ **YES** ☐ **NO**

If yes, what type: ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

SELECT BELOW	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
	LOADING DOSES	MG / KG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS	
	MAINTENANCE DOSE	5 MG / KG	IV	ONCE EVERY WEEKS	
	MAINTENANCE DOSE	10 MG / KG	IV	ONCE EVERY WEEKS	
	OTHER DOSE	MG / KG	IV	ONCE EVERY WEEKS	

LABS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	BENADRYL, PRN		
	ACETAMINOPHEN, PRN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

PREMEDS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	BMP	( ) PRIOR ( ) POST	
	CMP	( ) PRIOR ( ) POST	
	BUN/CREATININE	( ) PRIOR ( ) POST	
	CRP:	( ) PRIOR ( ) POST	
	ESR:	( ) PRIOR ( ) POST	
	Other:	( ) PRIOR ( ) POST	

NOTES/INSTRUCTIONS/COMMENTS

_____

_____

FLUSHES: ☐ 10 mL NS Flush Syringe PRN ☐ Heparin 500 units/5 mL Flush Syringe PRN ☐ NS 50 mL PRN

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

Fax completed form to the MRMC Infusion Center at 979-241-5965.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.