LHS LINCOLN Health System
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.