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

Infliximab (Remicade, Inflectra, Renflexis) Infusion 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?	☐ **Yes** ☐ **No**		
	If yes, please provide pharmacy name and contact number _____		
Diagnosis and ICD 10 Code			
Annual TB test date/Was TB test negative	**Date**_____	☐ **Yes** ☐ **No**	☐ **No TB test per provider**

Drug: ☐ **Remicade** ☐ **Inflectra** ☐ **Renflexis**	
Is this a first dose	☐ **Yes** ☐ **No**
Dosing Guideline (Medication will be dispensed in appropriate volume, and administered per product instructions)	Rheumatoid Arthritis initial dose 3 mg/kg Adult Crohn's Disease or Ulcerative Colitis 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)	☐ **3mg/kg =_____mg** ☐ **5 mg/kg_____mg** ☐ **10 mg/kg=_____mg** ☐**_____mg/kg =_____mg** (note doses will be rounded to nearest 100mg)
Dosing Frequency	☐ At **weeks 0, 2, 6, and then every 8 weeks** ☐ **Every 8 weeks** ☐ **Every_____ weeks**
Expiration of Prescription	☐ **3 months** ☐ **6 months** ☐ **12 months** ☐ **Other**

Pre-Medications: (Please mark all that apply)

- ☐ Tylenol 650mg po prior to infusion
- ☐ Benadryl 25mg IVP 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:** _____

Endeavor Health SM

Physician Name: _____ **Ordering Physician NPI:** _____
Office Phone Number: _____ **Swedish Hospital NPI: 1831151257**
Office Fax: _____

Revision/Review Date: 12/2024