



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

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Remicade (infliximab) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ Height (inches): _____ Weight (lbs): _____

3. Diagnosis:

[] Primary ICD-10 Code: _____ Diagnosis description: _____

[] Other ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications:

[] Acetaminophen:

[] 1000mg PO [] 500mg PO

[] Diphenhydramine:

[] 25mg PO [] 50mg PO [] 25mg IV [] 50mg IV

[] Hydrocortisone: 100mg IVP

[] Other Pre-medication: _____

[] No Pre-medications indicated

5. Drug Order:

Remicade (infliximab) Ok to substitute with generic/biosimilar

Dose: _____

Frequency: _____

Special Instructions: _____

[] New to Therapy

[] Continuing therapy: Last Dose Received _____ Next Dose Due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[] CBC & CMP within 2 weeks prior to infusion

[] Other: _____

[] No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.

The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. Required Baseline Lab/Testing have been completed:

[] Hepatitis B sAg, sAb, Core Ab total, date: _____ [] CBC/CMP, date: _____

[] TB status, date: _____ [] Other: _____

8. Patient Assistance & REMS Program Enrollment

[] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)

[] No, patient has not been enrolled in any programs.

7. Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

(This drug administration order form is valid for 12 months)