***Generic Substitute Unless Checked ❑**

ORDERS ARE IN EFFECT UNLESS CROSSED OUT
EXCEPTIONS: ORDERS PRECEDED BY A BOX (❑) REQUIRE A ✓ TO INITIATE ORDER
ORDERS WITH BLANKS INDICATE ADDITIONAL INFORMATION IS NEEDED

	* Patient Name	* Date of Birth
* Date	* Diagnosis	
	Allergies	
* Time	Code Status	❑ Full Code ❑ DNR ❑ Medications Only ❑ Other (SPECIFY)
	Vitals Signs	❑ Per Protocol ❑ Q30 minutes ❑ Other (SPECIFY)
	Lab Draws	❑ SGOT ❑ CBC ❑ Creatinine ❑ Albumin ❑ Other (SPECIFY)
	Frequency of lab test(s)	❑ Q8 weeks ❑ Q4 weeks ❑ Q2 weeks ❑ Other (SPECIFY)
	Vascular Access	❑ Port ❑ PICC ❑ CVC ❑ Start SL

Premeds

Acetaminophen	**Diphenhydramine**
❑ 500 mg PO ***OR*** ❑ 1000 mg PO	❑ 25 mg PO ***OR*** ❑ 50 mg PO

WARNING: Remicade increases the risk of TB, pneumonia, lymphomas, and can cause hepatoctoxicity

Frequency of Remicade infusions	❑ Series of 3 infusions at weeks 0, 2, and 6 ❑ Infusion Q8 weeks ❑ Other, please specify _____
*Remicade **DOSE**	❑ 5 mg/kg IV ❑ 10 mg/kg IV ❑ May round dose up to full vial amount ❑ Use exact amount only

Infusion:

- Include 1.2 micron (or smaller) in-line filter
- Infusion should begin within 2 hours of reconstitution
- Infuse over at least 2 hours
- Begin infusion at 10 mL/hr, increase to 40 mL/hr after 15 – 30 minutes, then after 15 minutes, increase rate to 80 – 250 mL/hour for the duration of the infusion as tolerated. *(Increasing the infusion in increments of 20 – 30 mL/hr every 10 – 15 minutes reduces side effects)*

Keep anaphylaxis kit at patient's bedside during infusion. Follow anaphylaxis protocol if allergic reaction occurs.

❑ Discharge patient when complete if stable and pain level is within tolerable range

Additional Orders _____
_____

* Healthcare Provider's Signature _____

- * Denotes field that must be completed by Healthcare worker

Fax to 503-815-7515

Tillamook Regional Medical Center – Adventist Health

Physician Order – Remicade Infusion

Outpatient Therapy Services

* 2 3 7 *
Physician Order Form

183939 Rev. 05/2012

[Patient Label]