FirstHealth OF THE CAROLINAS

7096.08.16152.01 Sunset Date: 6/2024

OP Remicade Referral

3POREF001

Place Patient Label Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below*****

Version 6/2021

Date of Infusion: _____

Patient Name: _____

Patient SSN (if available): _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:
- ☐ Moore Regional Hospital (MRH)
- ☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments ☐ Until _____

Nursing Orders	Interval	Duration
☐ Nursing Communication Once Patient is NOT to be infused if there are any signs or symptoms of infection	_____	_____
☐ Insert peripheral IV	_____	_____
Picc Access And Flush Orders		
☐ PICC Line Access	_____	_____
☐ Heparin, porcine (PF) 10 unit/mL injection 50 Units 50 Units, intravenous Once	_____	_____
Vascular Access Device (cvc) Access and Flush Orders		
☐ Central Venous Catheter (CVC) access	_____	_____
☐ Heparin, porcine (PF) injection 500 units, IV once 500 Units, intravenous, Once	_____	_____
Labs		
☐ CBC with auto differential	_____	_____
☐ Hepatic function panel	_____	_____
☐ Creatinine, serum	_____	_____
Pre-Medications		
☐ Sodium chloride 0.9 % infusion 500 mL 500 mL, intravenous, at 10 mL/hr, Once Carrier Fluid	_____	_____

Provider Signature: _____ Date: _____ Time: _____

* May be used as EPIC Downtime Form

Place Patient Label
Inside This Box

Pre-Medications (continued)	Interval	Duration
☐ diphenhydrAMINE (BENADRYL) capsule oral, Once, Starting 30 Minutes from start time	_____	_____
☐ methylPREDNISolone sodium succinate (Solu-MEDROL) injection 100 mg 100 mg, intravenous, Once, Starting 30 Minutes from start time	_____	_____
☐ cetirizine capsule 1 tablet 1 tablet, oral, Once, Starting 30 Minutes from start time	_____	_____
☐ fexofenadine (ALLEGRA) tablet oral, Once, Starting 30 Minutes from start time	_____	_____
☐ loratadine (CLARITIN) tablet 10 mg 10 mg, oral, Once, Starting 30 Minutes from start time	_____	_____
☐ acetaminophen (TYLENOL) tablet 162.5 mg 100 mg, oral, Once, Starting 30 Minutes from start time	_____	_____
☐ famotidine (PEPCID) injection 20 mg 20 mg, intravenous, Once, Starting 30 Minutes from start time Dilute with 10 ml of NS and infuse over 2 minutes	_____	_____
Medications		
☐ Remicade 500mg, intravenous. Use an in-line, non-pyrogenic,low protein binding filter with 1.2 micron pore size or less. Initiate infusion at a rate of 10 ml/hr x 15 min., then increase to 20 ml/hr x 15 min., then increase to 40 ml/hr x 15 min., then increase to 80 ml/hr x 15 min., then 150 ml/hr x 30 min., and then finally 250 ml/hr x 30 min. After infusion is completed, flush line with 15-20 ml of normal saline to ensure that all medication is administered to patient.	_____	_____
Nursing Communication		
☐ Stop Infusion and call Physician if adverse reaction occurs	_____	_____
Infusion Reaction Management		
☐ DiphenhydrAMINE (BENADRYL) injection 50 mg 50 mg, intravenous, Once as needed, itching	_____	_____
☐ methylPREDNISolone sodium succinate (Solu-MEDROL) injection 100 mg 100 mg, intravenous, Once as needed, for upper airway swelling	_____	_____
☐ Albuterol nebulizer solution 2.5 mg 2.5 mg, nebulization, Every 2 hour PRN, wheezing	_____	_____
☐ morphine injection 2 mg 2 mg, intravenous, Once as needed, for rigors/chills	_____	_____
☐ EPINEPHrine (ADRENALIN) injection 0.3 mg 0.3 mg, subcutaneous, Once as needed, anaphylaxis	_____	_____
☐ Sodium chloride 0.9 % bolus 500 mL 500 mL/hr, intravenous, for 1 Hours, Once as needed, for SBP < 90	_____	_____
☐ Nursing oxygen orders / instructions As needed O2 at 2 liters per minute via nasal cannula maintain sats >93 O2 at 2 liters per minute via nasal cannula to maintain sats > 93%	_____	_____

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ Date: _____ Time: _____

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