☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

ThrIVewell
INFUSION
Office: 212-803-3339 Fax : 646-768-8600

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

(infliximab-dyyb)

INFLECTRA infusion orders

Date: _____

Mission Medical

Patient Name _____ DOB _____

Phone _____ M ○ F ○

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Rheumatoid Arthritis
☐ _____ Psoriatic Arthritis
☐ _____ Plaque Psoriasis
☐ _____ Ankylosing Spondylitis
☐ _____ Crohn's Disease
☐ _____ Ulcerative Colitis
☐ _____ _____

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____

INFLECTRA ORDERS

DOSAGE

○ _____ mg/kg *weight-based*
○ _____ mg *flat-dosed*

PATIENT WEIGHT

_____ lbs.
_____ kg

FREQUENCY

○ every 0,2,6, and every 8 weeks *(induction)*
○ every _____ weeks

NOTES

_____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____