

(infliximab-dyyb)

INFLECTRA

Date: _____
infusion orders

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

REFERRAL STATUS

- ☐ New Prescription
☐ Order Renewal
☐ Does or Frequency Change
☐ Discontinuation

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 / IV *weight-based*
☐ _____ mg *flat-dosed*

FREQUENCY

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

PATIENT WEIGHT

_____ lbs.
_____ kg

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____