

☐ **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

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

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

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



☐ **Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021

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

☐ **Manhattan**
225 East 70th Street
New York, NY 10021

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

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

☐ **5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559

☐ **Long Beach**
917 Beech Street
Long Beach, NY 11561

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

(infliximab-dyyb)

INFLECTRA infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____

M ☐ F ☐
☐ Allergies _____

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

REFERRAL STATUS

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*

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 _____