Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

Inflectra (infliximab-dyyb)
Infusion Orders

Required Information:

- ☐ Signed order from prescribing provider
- ☐ Patient demographics including insurance information
- ☐ Supporting clinical documentation: Visit notes, diagnostic results
- ☐ Required Labs: TB & Hep B screening

Primary Diagnosis:

- ☐ Crohn's Disease (ICD-10 :_____)
- ☐ Ulcerative Colitis (ICD-10:_____)
- ☐ Rheumatoid Arthritis (ICD-10 :_____)
- ☐ Psoriasis (ICD-10 :_____)
- ☐ Ankylosing Spondylitis (ICD-10 :_____)

INFLECTRA ORDERS

☐ Inflectra _____mg/kg

Frequency: ☐ Induction: weeks 0, 2, 6, then every 8 weeks
☐ Subsequent: every _____ weeks

Date of Last Inflectra: _____

Administered per manufacturer guidelines

PRE-MEDICATIONS

☐ PO Tylenol _____mg

☐ PO Cetirizine _____mg

☐ IV Solu-medrol _____mg

☐ PO Loratadine _____mg

☐ PO ☐ IV Diphenhydramine _____mg

☐ PO ☐ IV Other:_____ _____mg

LABS

☐ CBC ☐ ESR ☐ Uric Acid

☐ CMP ☐ TB Quantiferon Gold ☐ Other:_____

☐ CRP ☐ Hep B Core/Surface AG ☐ Other:_____

Frequency:
- ☐ Every Visit
- ☐ Every Other Visit
- ☐ One time only
- ☐ Other:_____

CPL Acct #:_____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

_____

_____

_____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**