INFLECTRA (INFLIXIMAB-DYYB)
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This order signed by provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/progress notes, labs, tests supporting primary diagnosis
- ☐ TB & Hep B documentation, CBC & liver function should be followed at regular intervals.
- ☐ TB test attached
- ☐ **TB protocol:** Baseline testing: Quantiferon Gold or PPD
- ☐ Yearly TB testing (optional)
- ☐ **Hep B protocol:** Hep B surface antigen & Hep B Core AB total required

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

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

Q code: Q5102

Inflectra Orders

Inflectra Dose:_____mg/kg

Frequency:

- ☐ **Every_____weeks**

OR

- ☐ **0, 2, 6 then Every 8 weeks**

Protocol Pre-Medication Orders:

- ☐ **Tylenol l000mg PO,**
- ☐ **Diphenhydramine 25mg PO**

Additional premedication options:

- ☐ **Solu-Medrol _____ mg IV**
- ☐ **Solu-Cortef _____ mg IV**

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**

Physician Signature:	**Date:**

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