

(infliximab-dyyb)

# INFLECTRA infusion orders

Date: \_\_\_\_\_

## PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

## REFERRAL STATUS

New Referral    Referral Renewal    Medication/Order Change    Benefits Verification Only    Discontinuation Order

## PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

**DIAGNOSIS** *Please provide ICD-10 code*

\_\_\_\_\_ Rheumatoid Arthritis  
 \_\_\_\_\_ Psoriatic Arthritis  
 \_\_\_\_\_ Plaque Psoriasis  
 \_\_\_\_\_ Ankylosing Spondylitis  
 \_\_\_\_\_ Crohn's Disease  
 \_\_\_\_\_ Ulcerative Colitis

\_\_\_\_\_ (other)

**PRE-MEDICATION**

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

\_\_\_\_\_ (other)                                      \_\_\_\_\_ (other)

**INFLECTRA ORDERS**

**PATIENT WEIGHT**

\_\_\_\_\_ lbs.  
 \_\_\_\_\_ kg

**DOSAGE:**

• \_\_\_\_\_ mg/kg                      • x \_\_\_\_\_ days  
 • \_\_\_\_\_ mg/kg over

Other \_\_\_\_\_

**Frequency:**

every 0,2,6,and every 8 weeks  
 every \_\_\_\_\_ weeks  
 Other \_\_\_\_\_

**NOTES/ADDITIONAL COMMENTS:**

  
  
  
  
  

## ORDERING PROVIDER

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_