

(infliximab-dyyb)

INFLECTRA

Date: _____

infusion orders

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

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