

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



I N F U S I O N

Office: 212-803-3339 Fax : 646-768-8600



(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
- Diphenhydramine 25mg PO
- Cetirizine 10mg PO
- Solu-Medrol 125mg IVP
- Solu-Cortef 100mg IVP
- 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 _____