

Inflectra Order

(Infliximab-dyyb)



Ph: 805-719-3700 | Fax: 805-852-2636

Date: ____ / ____ / ____ Treatment Location: _____

***Please fax a copy of the following patient information:** Demographics Insurance Information Current Lab Results
 H & P Relevant to the Diagnosis Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: ____ / ____ / ____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____ / ____ / ____

Phone: (____) ____ - ____ Fax: (____) ____ - ____

Office Address: _____

Contact Person: _____

PRE-MEDICATIONS:

Benadryl: PO IV 25mg 50mg Pre-med PRN

Acetaminophen: PO 650mg Pre-med PRN

Claritin or Zyrtec PO 10mg Pre-med PRN

Solu-Medrol: IV ____ mg Pre-med PRN

Normal Saline Bolus: IV 250mL Pre-med PRN

Zofran: PO IV ____ mg Pre-med PRN

INFLECTRA (INFLIXIMAB-DYYB) IV DOSAGE

3mg/kg 5 mg/kg 7.5 mg/kg 10 mg/kg Total Dose: _____

Frequency: Initial dose at 0, 2, 6 weeks, **then** Q 4 weeks Q 6 weeks Q 8 weeks

Next dose due: ____ / ____ / ____