

INFLECTRA (INFLIXIMAB-DYYB) INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
☐ TB & Hepatitis B documentation, CBC and Liver function should be followed at regular intervals
☐ TB Test Attached
☐ **TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening (*Optional*)
☐ **Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

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

Q code: Q5102

INFLECTRA ORDERS

Inflectra Dose: _____ mg/kg **Pt. Weight** _____ kg

Frequency: Every _____ weeks or ☐ 0, 2, 6 then Every 8 weeks

P1 otocol Pre-Medication Orders: Tylenol 1000mg PO, *please choose one antihistamine:*

- ☐ Cetirizine 10mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Loratadine 10mg PO

Additional Pre-Medication Orders:

☐ Solu-Medrol _____ mg IV

☐ Solu-Cortef _____ mg IV

****Date of last** ☐ Orencia ☐ Remicade ☐ Humira or ☐ Enbrel dose:_____ ☐ Date:_____

Additional Instructions:

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Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	