

Inflectra® (infliximab-dyyb) Order Form

Please include the following (required):

- 1. Patient Demographics & Insurance Information
- 2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
- 3. TB screening and Hepatitis B vaccine or testing documentation.

Patient Name	DOB		
Height	Weight	Allergies	Patient Phone

Diagnosis (must include ICD-10 code)

- Rheumatoid Arthritis _____ Psoriatic Arthropathy _____
- Psoriasis _____ Ankylosing Spondylitis _____
- Crohn's Disease _____ Ulcerative Colitis _____
- Other (ICD-10 Code): _____

Prescription Orders: Inflectra® (infliximab-dyyb) (quantity: 100 mg per vial)
0.2-micron filter must be used during infusion

- Initial Dosing: _____ mg/kg IV on day 0, 2 weeks, 6 weeks, and then every _____ weeks.
- Renewal Dosing: _____ mg/kg IV every _____ weeks. (date of last infusion _____)

Pre-Medications:

- Acetaminophen 650mg PO Benadryl 25 mg IVP Solu-Medrol 40mg IVP
- Benadryl 50 mg IVP Solu-Medrol 125 mg IVP
- Other _____

Standing Lab Orders: CMP CBC ESR CRP Other: _____
 every infusion every other infusion

Refills: 12 months or for _____ infusions

Provider Name	Phone	Fax
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Provider's signature	Date
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Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com