



Phone:616-954-0600 Fax: 616-954-1675

Infliximab IV Infusion

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and Recent Visit Notes

Referral status: NEW referral Dose or frequency change Order renewal

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Patient Weight: _____ lbs / kg Height: _____

ICD-10 : _____, _____, _____

In the past year, what medications for the above diagnosis has the patient tried and failed?

N/A continuation of treatment

Drug	Dose	Dates of use

TB verification (circle one): TB skin test TB spot/Quantiferon blood test Chest X-RAY

Result Date: ____/____/____ Result (circle one): Positive Negative

Labs to be collected: CMP CBC w/o diff CBC w/diff CBC w/man diff CRP ESR Other: _____

Lab Frequency: EVERY infusion Every OTHER infusion Other: _____

Pre-Medications:

Diphenhydramine PO or IV	25mg or 50mg	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cetirizine PO	10mg	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acetaminophen PO	650mg	<input type="checkbox"/> Yes <input type="checkbox"/> No
Methylprednisolone IV	____mg	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV infliximab: Pharmacist to select product

Inflectra (infliximab-dyyb) Remicade (infliximab-hjmt) Renflexis (infliximab-abda)

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

Frequency: Initial Dose – 0, 2, 6wks, THEN either q 6 wks or q 8 wks Other: _____

WHEN CALCULATING DOSE:

ROUND to nearest vial (100 mg per vial)

ROUND to the nearest half vial (50 mg increment)

Dose: _____

Continuation of treatment RX Expiration Date: ____/____/____

Printed provider name: _____

Provider signature: _____

Office phone number: _____ Fax number: _____