6415 Fort Apache Road, Suite #175
Las Vegas, NV 89148
Phone: 702-665-5730
Fax: 702-780-4887

Inflectra (infliximab-dyyb) **infusion orders**

Patient Name: ____ Date of Birth: ___________________

Address: ____ Phone Number: _________________

Gender: _______ Height: _____ Weight: _____ (lb./kg)

Diagnosis

☐_____ Rheumatoid Arthritis
☐_____ Psoriatic Arthritis
☐_____ Plaque Psoriasis
☐_____ Ankylosing Spondylitis
☐_____ Eosinophilic Asthma
☐_____ Crohn's Disease
☐_____ Ulcerative Colitis
☐______________________

Pre-Medication

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125 IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ ________________________
☐ ________________________

Orders

Dosage
______ **mg/kg** **weight-based**
______ **mg** **flat-based**

Frequency
☐ every 0,2,6, and every 8 weeks (induction)
☐ every _________ weeks

_________ Refills

Notes

____

____

Ordering Provider

Signature: ____Date: _____________________

Provider:____________________________________ Phone: ________________ Fax: ________________

Address: ____

NPI: _____________________________________ DEA: ____