Local Infusion

MYLOCALINFUSION.COM

INFLECTRA (INFLIXIMAB-DIYYB) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________ DOB: __________

Mobile Number: ______________ Patient Weight: ______________

Allergies: ______________________

DIAGNOSIS (Provider must specify)

- ❑ Rheumatoid Arthritis, ICD 10: M05.____ or M06.____
- ❑ Plaque Psoriasis, ICD 10: L40.0
- ❑ Psoriatic Arthritis, ICD 10: L40.__________
- ❑ Ankylosing Spondylitis, ICD 10: M45.__________
- ❑ Crohn's Disease, ICD 10: K50.__________
- ❑ Ulcerative Colitis, ICD 10: K51.__________
- ❑ Other: ______________________

PROVIDER INFORMATION

Provider Name (print name): ______________________ Provider NPI: __________

Signature: ______________________ Date: __________

Contact Name: ______________ Phone: __________ Fax: __________

Email Address: ______________________

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

- ❑ Acetaminophen (Tylenol) 500 mg PO
- ❑ Benadryl 25mg PO
- ❑ Famotidine 20 mg IV
- ❑ Cetirizine (Zyrtec) 10 mg PO
- ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ❑ Other: ______________ Dose: __________ Route: __________

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Inflectra	❑ ______ mg/kg ❑ ______ mg	❑ IV	❑ Weeks 0, 2, 6 and then every 8 weeks ❑ Every 8 weeks ❑ Every ____ weeks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): ______________

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ CT: 203.433.0621 ❑ ME: 207.407.7272 ❑ NH: 603.217.5371 ❑ NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: __________