



Inflectra Infusion Order

Fax 281-715-5302 Phone 281-265-0100

Patient Name: _____
Patient Phone: _____

DOB: _____
SEX: M F

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: K50.90 Crohn's disease, unspecified, without complications
K51.90 Ulcerative colitis, unspecified, without complications
M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
M06.9 Rheumatoid arthritis, unspecified
Other _____

ICD-10 _____

Patients weight: _____
Lab Date: _____
Allergies: _____

ALSO INCLUDE...

Clinical/ Progress Notes
Demographics Sheet
Current Medications
Labs

INFLECTRA ORDER

Patients Weight: _____ kg

Inflectra Dose: Initial/Reload Dosing: _____ mg/kg IV on day 0, 2 weeks, 6 weeks then every _____ 6 or 8 weeks.
Maintenance Dosing: _____ mg/kg IV every _____ 6 or 8 weeks.
5mg/kg 3mg/kg other: _____ mg/kg

PreMeds: Benadryl APAP Famotidine (IV) Hydrocortisone

Date of last Inflectra Infusions: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature _____ **Date:** _____