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# INFLECTRA infusion orders (infliximab-dyyb)

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_  
Phone \_\_\_\_\_ M  F

### DIAGNOSIS Please provide ICD-10 code

- |   |   |
|---|---|
| <input type="checkbox"/> _____ Rheumatoid Arthritis   | <input type="checkbox"/> _____ Crohn's Disease    |
| <input type="checkbox"/> _____ Psoriatic Arthritis    | <input type="checkbox"/> _____ Ulcerative Colitis |
| <input type="checkbox"/> _____ Plaque Psoriasis       | <input type="checkbox"/> _____                    |
| <input type="checkbox"/> _____ Ankylosing Spondylitis |   |

### PRE-MEDICATION

- |  |   |
|--|---|
| <input type="checkbox"/> Tylenol 1000mg PO       | <input type="checkbox"/> Solu-Medrol 125mg IVP    |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP    |
| <input type="checkbox"/> Cetirizine 10mg PO      | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> _____                   | <input type="checkbox"/> _____                    |

### INFLECTRA ORDERS

<p><b>DOSAGE</b></p> <p><input type="radio"/> _____ mg <i>flat-dosed</i></p> <p><input type="radio"/> _____</p> <p>Notify MD if patient weight changes by _____ lbs. / kg (please circle)</p> <p><b>FREQUENCY</b></p> <p><input type="radio"/> every 0,2,6, and every 8 weeks (<i>induction</i>)</p> <p><input type="radio"/> every _____ weeks</p>	<p><b>PATIENT WEIGHT</b></p> <p>_____ lbs.</p> <p>_____ kg</p>
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### NOTES

\_\_\_\_\_

### ORDERING PROVIDER

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_