RED RIVER HEALTH
Ambulatory Infusion Clinic

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INFLECTRA (infliximab-dyyb) Infusion Orders

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Rheumatoid Arthritis (RA)
☐ _____ Psoriatic Arthritis (PA)
☐ _____ Plaque Psoriasis
☐ _____ Ankylosing Spondylitis
☐ _____ Crohn's Disease (CD)
☐ _____ Ulcerative Colitis (UC)
☐ _____ _____ *(other)*

Pre-Medication:

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

Required Documents:

☑ Patient Demographic Sheet
☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☑ TB Status & Date *(please attach results)*
☑ HepB Status & Date *(please attach results)*

INFLECTRA ORDERS:

Dosing: ☐ _____mg/kg *(weight based)* **Pt. weight:** _____
(ensure unit of measure is noted)
☐ _____mg *(flat-dosed)*

Frequency: ☐ Every 0, 2, 6, and every 8 weeks ☐ Other: _____
☐ Every _____ weeks

Refills: _____
(if not indicated, Rx will expire one year from date signed)

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date: