175 Memorial Highway. Suite 1-1
New Rochelle, NY
10801

914-460-4891
fuse@fuseinfusion.com
914-460-4571

(infliximab-dyyb)

INFLECTRA infusion orders

Patient Name ______________________ DOB __________

Phone ______________________ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ ________ Rheumatoid Arthritis (RA)
- ☐ ________ Psoriatic Arthritis
- ☐ ________ Plaque Psoriasis
- ☐ ________ Ankylosing Spondylitis
- ☐ ________ Crohn's Disease
- ☐ ________ Ulcerative Colitis
- ☐ ________ ______________________ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg IV
- ☐ Cetirizine 10mg IV
- ☐ Diphenhydramine 25mg IV
- ☐ ______________________
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ ______________________ *(other)*

INFLECTRA ORDERS

DOSAGE

- ○ ________ mg/kg *weight based*
- ○ ________ mg *flat-dosed*

FREQUENCY

- ○ every 0,2,6, and every 8 weeks *(induction)*
- ○ every ________ weeks

PATIENT WEIGHT

________ lbs.

________ kg

NOTES

____

ORDERING PROVIDER

Signature **X** ______________________ Date __________

Provider ______________________ Phone __________ Fax __________

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