Infusion Associates
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Grand Rapids, MI 49525
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Infliximab IV Infusion Order

*****Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

DX CODES: ***ICD-10*** : _____, _____, _____

TB verification ***(circle one):*** **TB skin test TB spot/Quantiferon blood test Chest X-RAY □ COPY ATTACHED**

Result Date: _____/_____/_____ Result ***(circle one):*** **Positive Negative**

LABS to be drawn: □ **CBC** □ **CMP** □ Other: _____Lab Frequency**:** _____

Pre- Medications:			
	Diphenhydramine PO or IV	**25mg or 50mg**	**□Yes □ No**
	Cetirizine PO	**10mg**	**□Yes □ No**
	Acetaminophen PO	**650mg**	**□Yes □ No**
	Solu-Medrol IV	**_____mg**	**□Yes □ No**

IV infliximab: □ Pharmacist to select product

□ **Inflectra (i*nfliximab-dyyb*)** □ **Remicade (i*nfliximab-hjmt*)** □ **Renflexis *(infliximab-abda)***

Dose: □ **3mg/kg** □ **5mg/kg** □ **7.5 mg/kg** □ **10mg/kg** □ **Other: _____**

WHEN CALCULATING DOSE:
□ **ROUND to nearest vial (100 mg per vial)**
□ **ROUND to the nearest half vial (50 mg increment)**
□ **Dose:_____**

Frequency: □ **Initial Dose – 0, 2, 6wks, then either □ q 6 wks or □ q 8 wks □ Other: _____**
□ **Continuation of treatment**

Start Date of Infusion: _____/_____/_____ **Expiration Date**: _____/_____/_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____ **Fax Number:** _____