(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 PO
Cetirizine 10mg PO
Diphenhydramine 25mg PO

Solu-Medrol 125mg IVP
Solu-Cortef 100mg IVP
Diphenhydramine 25mg IVP
(other)

INFLECTRA ORDERS

DOSAGE

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

PATIENT WEIGHT

lbs.
kg

FREQUENCY

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

NOTES

ORDERING PROVIDER

Signature **X** ______________________________ Date

Provider Phone Fax

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