Intravene – Infliximab Infusion Orders (rev 8/2023)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434) 455-5531 or call (434) 947-3900 ext. 3001

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____
Height _____ Weight _____lbs
Drug Allergies_____
□ NKDA Sex: □ Male or □ Female

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone(_____)_____
Physician Fax(____)_____
NPI#_____DEA#_____
State License#_____

****Please fax copies of insurance cards****
and this form to 434-455-5531

DIAGNOSIS: (ICD-10 required)

☐ _____ _____
☐ _____ _____
☐ _____ _____
☐ _____ _____

Please Mark One

□ Patient **IS** on methotrexate **OR** □ Patient is **NOT** on methotrexate

PRE TREATMENT SCREENING:

Tuberculosis Screening: Date/Results of TB test_____
Hepatitis B Screening: Date/ Results:_____
Hepatitis C Screening: Date/Results:_____

STANDARD ORDERS:

Infuse Infliximab _____ mg/kg (rounded to the nearest 100mg) in Normal Saline 250ml (Total Volume) over 2 hours for 1 year. Upon completion of Infliximab treatment, infuse Normal Saline 20ml to clear line.
(Rheumatoid arthritis standard dose=3mg/kg. Crohn's disease/ulcerative colitis/ankylosing spondylitis/psoriatic arthritis/plaque psoriasis standard dose=5mg/kg

Premedication:Diphenhydramine 25mg p.o. 30 min. prior to infusion on all except first dose.

Last infusion date (if applicable):_____

FREQUENCY OF INFUSIONS:

☐ *RHEUMATOID ARTHRITIS/CROHN'S DISEASE/ULCERATIVE COLITIS/PSORIATIC ARTHRITIS/PLAQUE PSORIASIS :* 0, 2, 6 weeks, then every 8 weeks thereafter
☐ *ANKYLOSING SPONDYLITIS: 0, 2, 6 weeks, then every 6 weeks thereafter*.
OTHER: _____

LAB ORDERS**:**
☐ NONE ☐ CBC EVERY_____ ☐ OTHER:_____

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

Signature, prescribing MD _____Date _____