

## Infliximab Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

Height: \_\_\_\_\_ (cm) Actual Weight: \_\_\_\_\_ (kg) Allergies: \_\_\_\_\_

Required labs: TB and HBV screening prior to therapy. CBC and CMP prior to therapy, then suggested every 3 to 6 months.

\* The Preferred Infliximab product at New England Cancer Specialists is: Renflexis (*infliximab-abda*):

- CPT Code: Q5104

\* If a different Infliximab product is needed, indicate the brand and rationale below:

- Different Infliximab product and rationale:

\_\_\_\_\_

### Pre-medications- prior to Infliximab:

- None
- Acetaminophen 1000mg PO
- Cetirizine 10 mg PO
- Dexamethasone 10mg IV

- Ankylosing spondylitis: *\*Please check all that apply\**  
Dose 5mg/kg:  Initial,  2 weeks,  6 weeks  q6 weeks  
Orders valid through \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Plaque psoriasis, Ulcerative colitis, Psoriatic arthritis, Crohn's disease:  
*\*Please check all that apply\**  
Dose 5mg/kg:  Initial,  2 weeks,  6 weeks,  q8 weeks  
 Alternate dosing: \_\_\_\_\_.  
Orders valid through \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Rheumatoid Arthritis: *\*Please check all that apply\**  
Dose 3mg/kg:  Initial,  2 weeks,  6 weeks,  q8 weeks  
 Alternate dosing: \_\_\_\_\_.  
Orders valid through \_\_\_\_ / \_\_\_\_ / \_\_\_\_

In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

Provider Name: \_\_\_\_\_  
Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Pager: \_\_\_\_\_