

Infliximab Order Form

Patient Name	Middle	Last	DOB
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Diagnosis	Diagnosis Code
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Height (cm)	Actual Weight (kg)	Allergies
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*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:
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PRE-MEDICATIONS- PRIOR TO INFLIXIMAB:

- None Cetirizine 10 mg PO
 Acetaminophen 1000mg 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
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Date	Phone	Fax	Pager
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