NEW ENGLAND
Cancer Specialists

Infusion Center

KENNEBUNK | ROCK ROW | TOPSHAM | PORTSMOUTH
PHONE: (207) 303-3225 | FAX: (207) 692-2473

Infliximab Order Form

Patient Name | Middle | Last | 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