vitalcare of SAN ANGELO

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# INFLECTRA (INFLIXIMAB-DYYB) INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
- ☐ TB & Hepatitis B documentation, CBC and Liver function should be followed at regular intervals
- ☐ TB Test Attached
- ☐ **TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*
- ☐ **Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.

| **Patient Name:** | **DOB:** |
|---|---|
| **Allergies:** | **Patient Phone:** |

**Diagnosis:**

☐ Crohn's Disease (ICD-10_____) ☐ Ulcerative Colitis (ICD-10_____)

☐ Rheumatoid Arthritis (ICD-10_____) ☐ Ankylosing Spondylitis (ICD-10_____)

☐ Psoriasis (ICD-10_____) ☐ Other_____ (ICD-10_____)

**Q code: Q5102**

## INFLECTRA ORDERS

**Inflectra Dose:**_____mg/kg Pt. Weight _____ kg

**Frequency:** Every_____weeks or ☐ 0, 2, 6 then Every 8 weeks

**P1 otocol Pre-Medication Orders:** Tylenol l000mg PO, *please choose one antihistamine:*

☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

**Additional Pre-Medication Orders:** ☐ Solu-Medrol _____ mg IV
☐ Solu-Cortef _____ mg IV

****Date of last** ☐ Orencia ☐ Remicade ☐ Humira or ☐ Enbrel dose:_____ ☐ Date:_____

**Additional Instructions:**

| **Physician Name:** | **Phone:** | **Fax:** |
|---|---|---|
| ****Physician Signature:** | **Date:** | |