Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Inflectra (Infliximab-dyyb)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)
☐ Richmond ☐ Prince George

If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required.

DIAGNOSIS AND ICD-10 CODE	
☐ Moderate to Severe Ulcerative Colitis	K51.90
☐ Moderate to Severe Crohn's Disease	K50.90
☐ Rheumatoid Arthritis	M06.9
☐ Ankylosing Spondylitis	M45.9
☐ Psoriatic Arthritis	L40.50
☐ Plaque Psoriasis	L40.0
☐ Other: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ Negative QuantiFERON Gold TB Test or Skin PPD	☐ HBV Panel results
☐ Patient currently receiving same therapy at _____ Last dose: _____	
List Tried & Failed Therapies, including duration of treatment	
1)	3)
2)	4)

MEDICATION ORDERS**	
Initial Dosing	☐ Inflectra 3mg/kg infuse IV over 2 hours at week 0, 2, 6, then every 8 weeks
	☐ Inflectra 5mg/kg infuse IV over 2 hours at week 0, 2, 6, then every 8 weeks
	☐ Inflectra ____ mg/kg infuse IV over 2 hours at week 0, 2, 6, then every 8 weeks
Maintenance Dosing	☐ Inflectra 5mg/kg infuse IV over 2 hours every 8 weeks
	☐ Inflectra 10mg/kg infuse IV over 2 hours every 8 weeks
Alternative Dosing	☐ Inflectra ____ mg/kg infuse IV over 2 hours every ____ weeks

Patient Weight: _____ kg or _____ lb Patient Height: _____ in
Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____

**For all weight-based therapies, Infusion Solutions will obtain/verify a patient's current weight within one week of dosing.

OPTIONAL PREMEDICATIONS and LAB ORDERS
☐ Acetaminophen 650mg PO prior to infusion
☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion
☐ Methylprednisolone 40mg slow IVP prior to infusion
☐ CMP drawn yearly
☐ Other premed or lab order with frequency : _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.