Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

INFUSE ONE

Infliximab infusion orders

Patient Name _____ DOB _____

Phone Number _____ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis
- ☐ _____ Psoriatic Arthritis
- ☐ _____ Plaque Psoriasis
- ☐ _____ Ankylosing Spondylitis
- ☐ _____ Crohn's Disease
- ☐ _____ Ulcerative Colitis
- ☐ _____ Other

PRE-MEDICATIONS

- ☐ Acetaminophen 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ (other)
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ (other)

Infliximab ORDERS

INFLIXIMAB PRODUCT

- ☐ Remicade
- ☐ Avsola
- ☐ Inflectra
- ☐ Renflexis

DOSAGE

- ☐ _____ mg/kg *(weight-based)*
- ☐ _____ mg *(flat-dosed)*

FREQUENCY

- ☐ every 0,2,6, & 8 weeks *(induction)*
- ☐ every _____ weeks

Patient Weight

_____ lbs

_____ kg

NOTES:

- Please fax the patient's TB and Hepatitis B test results with this completed form

ORDERING PROVIDER

Signature _____ Phone_____Fax_____

Provider _____ Date _____