Phone and Fax: 608-690-7210
Email: info@MySmartInfusion.com
www.MySmartInfusion.com

Inflectra (Infliximab-dyyb)
Infusion Order Form

Patient Information

Patient Name: ____DOB: ____________________ M ☐ F ☐

Allergies: ____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: ____________ Next Due Date: ____________

Diagnosis and ICD 10 Code (Required)

☐ Moderate to Severe Ulcerative Colitis ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease ICD 10 Code: K50.90
☐ Rheumatoid Arthritis ICD 10 Code: M06.9
☐ Other: ______________________ ICD 10 Code: _______
☐ Ankylosing Spondylitis ICD 10 Code: M45.9
☐ Psoriatic Arthritis ICD 10 Code: L40.52
☐ Plaque Psoriasis ICD 10 Code: L40.0

Required Tests (within 12 months & attach results)

TB/ Quantiferon Status & Date: ______________________
Hepatitis B Status & Date: __________________________

Required Labs (within 3 months & attach results)

CBC Results ________________________________
CMP Results ________________________________
CRP Results ________________________________
Other: ____________________________________

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg ☐ PO
Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
Methylprednisolone (Solu-Medrol) ☐ 125mg ☐ IV
Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV
Other: ______________________ Route: ____________
Dose: ____________ Frequency: ___________________

Nursing

Provide nursing care per Smart Infusion Nursing Procedures,
Including reaction management and post-procedure observation.

Special Instructions / Notes

Inflectra Medication Orders

Patient Weight: ____________ KG

Dosage
☐ 3mg/kg IV ☐ 5mg/kg IV ☐ 10mg/kg IV
☐ __________mg/kg

Frequency
☐ Induction week 0, 2, 6 then every 8 weeks
☐ Maintenance every 8 weeks
☐ Other ________________________________

Required Documents
☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical and Progress Notes

Provider Information

Provider Name: ____ Provider NPI: ____________________

Office Phone: ___________________________________ Office Fax: ________________________________

Provider Signature: ____ Date: ____________________