CURBSIDE
INFUSION SERVICES

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Office: (877) 428-7248
Scheduling@curbsideinfusion.com Ext. 0
Billing@curbsideinfusion.com Ext 1

INFLECTRA (infliximab-dyyb) infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis (RA)
- ☐ _____ Psoriatic Arthritis
- ☐ _____ Plaque Psoriasis
- ☐ _____ Ankylosing Spondylitis
- ☐ _____ Crohn's Disease
- ☐ _____ Ulcerative Colitis
- ☐ _____ _____ *(other)*

PRE-MEDICATION

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

INFLECTRA ORDERS

DOSAGE

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

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

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

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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