CONSULTANTS INC
SPECIALIZING IN INFECTIOUS DISEASES

Ambulatory Infusion Center

Parkway Medical Center
3609 Park East Drive #207
Beachwood, OH 44122

216-360-0456 TEL
216-378-9824 FAX
216-360-9449 ALT FAX
www.idconsultants.com/aic

MEDICATION ORDERS – INFLECTRA (infliximab-dyyb)

Date of Referral: _____ Office Location: ☐ Beachwood ☐ Middleburg Heights ☐ Painesville

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ WT (kg): _____ HT (in): _____

Diagnosis: _____ ICD10 Code: _____

Allergies: _____

PLEASE FAX SUPPORTING CLINICAL DOCUMENTATION, INCLUDING MEDICAL RECORDS/PROGRESS NOTES, LABS, and INSURANCE INFORMATION (both front and back of the card) ALONG WITH THIS FORM

INFLECTRA DOSING

- ☐ Inflectra dose of 3 mg/kg
- ☐ Inflectra dose of 5 mg/kg
- ☐ Round to the nearest 100 mg
- ☐ Inflectra specific dose of _____

FREQUENCY:

- ☐ Loading dose on day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter
- ☐ Specific dose frequency of _____

- ☐ Premed orders: _____
- ☐ Special Needs/Consideration: _____

Date of last TB test: _____ Results: _____
If positive, date of negative chest x-ray: _____

Date of Hep B screen: _____ Results: _____
Date of Hep B Surface Antigen (HBsAg): _____Results: _____
Date of Hep B Surface Antibody (HBsAb/ anti- HBs): _____ Results: _____
Date of Hep Core Antibody total (HBcAb/ anti-HBc): _____ Results: _____

Prescribing Physician: _____
Address: _____
Physician Signature: _____ Date: _____
Physician Phone: _____ Fax: _____

LAB REQUIREMENTS and LAB MONITORING ARE THE RESPONSIBILITY OF THE PRESCRIBING PHYSICIANS