vitalcare of CENTRAL MISSISSIPPI
Fountains Infusion Center
159 Fountains Blvd. Madison MS, 39110
Phone: 601.859.8200 Fax: 601.859.8201

INFLIXIMAB
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
☐ TB & Hepatitis B documentation, CBC and Liver function should be followed at regular intervals
☐ TB Test Attached
☐ **TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*
☐ **Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Crohn's Disease (ICD-10_____) ☐ Ulcerative Colitis (ICD-10_____)
☐ Rheumatoid Arthritis (ICD-10_____) ☐ Ankylosing Spondylitis (ICD-10_____)
☐ Psoriasis (ICD-10_____) ☐ Other_____ (ICD-10_____)

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Infliximab: ☐ Infuse infliximab **OR** infliximab biosimilar as required by patient's insurance (Remicade, Inflectra, Avsola, Renflexis)
(choose one)
☐ Do not substitute. Infuse the following infliximab product:_____

Infliximab Dose:_____mg/kg Weight _____ kg

Frequency: Every_____weeks or ☐ 0, 2, 6 then Every 8 weeks **Refills:**_____

Pre-Medication Orders: Tylenol 650mg PO, *please choose one antihistamine:*
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IV
☐ Solu-Cortef _____ mg IV

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

Lab orders: _____ **Frequency:** _____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	