Inflectra

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

Labs Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

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

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) 500mg 650mg 1000mg PO
Diphenhydramine (Benadryl) 25mg 50mg PO IV
Cetirizine (Zyrtec) 10mg PO
Methylprednisolone (Solu-Medrol) 40mg IV 125mg IV
Loratadine (Claritin) 10mg PO
Hydrocortisone (Solu-Cortef) 100mg IV

Other: ______________________________________ Dose:__________________ Route:__________________ Frequency: __________________

MEDICATION ORDER

Venofer

Dose: Venofer 200mg IV **Frequency:** 5 doses over a 14 day period

Dose: Venofer 200mg IV **Frequency:** weekly x 5 weeks

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

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Provider Name **Provider Signature** **Date** Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.