METRO INFUSION CENTER

Phone: 877.448.3627

Fax completed form to:
866-507-1164

INFUSION ORDERS — INFLECTRA (Infliximab)

Date of referral: ____

Patient Name: ____ Date of Birth: ____

Address: ____

City: ____ State: ________________ ZIP Code: ________________

Phone: ____ WT (kg): ________________ HT: ________________(in)

Diagnosis: ____

Allergies: ____ TB Test Results: ____

Hepatitis B Surface Antigen Result: ____

***ICD 10 CODE:** ____*

Please include supporting clinical documentation for specified ICD 10 Code as well as demographic and insurance information. This must be provided to ensure payment by insurance carrier. Please fax with this order form.

Initial appointment date and time will be verified after insurance approval.

INFLECTRA DOSING

Frequency

- ☐ Inflectra dose of 3mg/kg
- ☐ Inflectra dose of 5mg/kg
- ☐ Inflectra dose of 7.5mg/kg
- ☐ Inflectra dose of 10mg/kg
- ☐ Inflectra specific dose of ____________

- ☐ Loading dose of day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter
- ☐ specific dosing frequency of ________________________________

Premedication of: ____

Prescribing Physician: ____

Address: ____

Physician Signature: ____

Date: ____

Physician Phone: ____ Fax: ____________________________