Mankato Clinic
Together we thrive.

ADULT AMBULATORY INFUSION ORDER

Infliximab (REMICADE)
Infliximab-abda (RENFLEXIS)
Infliximab-dyyb (INFLECTRA)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Date: _____/_____/_____

*__Please fax a copy of the following patient information__: ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Last infusion note ☐ Current Medications

PATIENT INFORMATION

Allergies: _____

Weight: _____ lbs/kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____/____/_____

Phone: (____)_____-_____ Fax: (____)____-_____

Office Address: _____

Contact Person: _____

TB Test Date: ____/_____/____ Result: _____ ☐ Copy Attached

Hep B Date: ____/_____/_____ Result: _____ ☐ Copy Attached

PRE-MEDICATIONS:

Diphenhydramine: ☐ PO ☐ IV ☐ 25 mg ☐ 50mg

Acetaminophen: ☐ PO ☐ 650 mg ☐ 1000 mg

Solu-Medrol: ☐ IV ☐ _____ mg

Other OTC: ☐ _____

☐ No Pre-Medications

WAIT TIME AFTER PRE MEDICATIONS:

☐ 20 minutes ☐ 30 minutes ☐ Other: _____ ☐ No wait time

LABS:

☐ CBC w/diff	☐ EVERY infusion	☐ every OTHER infusion	☐ other: _____
☐ CMP	☐ EVERY infusion	☐ every OTHER infusion	☐ other: _____
☐ CRP	☐ EVERY infusion	☐ every OTHER infusion	☐ other: _____
☐ ESR	☐ EVERY infusion	☐ every OTHER infusion	☐ other: _____
☐ Other: _____	☐ EVERY infusion	☐ every OTHER infusion	☐ other: _____

☐ No labs needed

Please check preferred product:

☐ **Remicade (INFLIXIMAB) IV DOSING**

☐ **Renflexis (Infliximab-abda) IV DOSING**

☐ **Inflectra (Infliximab-dyyb) IV DOSING**

☐ 3 mg/kg ☐ 5 mg/kg ☐ 7.5 mg/kg ☐ 10 mg/kg

☐ Round to the nearest vial (100 mg per vial)

☐ Total dose = _____ mg

Frequency: ☐ Initial dose at 0, 2, 6 weeks **then** ☐ Q 4 weeks ☐ Q 6 weeks ☐ Q 8 weeks

Next dose due: ____ /___ /____