



Infliximab - dyyb (Inflectra®) Order Form

FAX to 1 (888) 797-4008

PATIENT INFORMATION		
Patient Name:	DOB:	
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is patient a Wayne Health patient registered in athena? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Order date:	Weight: kg	Height: m
Drug allergies: <input type="checkbox"/> NKDA. <input type="checkbox"/> YES. Please specify.		
ICD-10 diagnosis:		

LABORATORY DATA		
CBC:	BMP:	Serology:
Other:		
TB Screening		
TST (PPD): <input type="checkbox"/> Not done <input type="checkbox"/> 5-9 mm <input type="checkbox"/> 10-14 mm <input type="checkbox"/> ≥ 15 mm Date of test:		
IGRA: <input type="checkbox"/> Not done <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate/Borderline Date of test:		

Infliximab (Remicade®)		
Dose	Directions	Refills
<input type="checkbox"/> 3 mg/kg <input type="checkbox"/> 10 mg/kg	<input type="checkbox"/> q 2 wks <input type="checkbox"/> q 8 wks	
<input type="checkbox"/> 5 mg/kg <input type="checkbox"/> Other:	<input type="checkbox"/> q 6 wks <input type="checkbox"/> Other:	

ORDERING PHYSICIAN INFORMATION	
Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.