UNIVERSITY OF MICHIGAN HEALTH-WEST
MICHIGAN MEDICINE
Infusion Center

Infliximab IV Infusion

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes**.

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Allergies: _____ Patient Weight: _____lbs/kg Height: _____

ICD-10: _____, _____, _____

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use

TB verification *(check one):* ☐ **TB skin test** ☐ **TB spot/Quantiferon blood test** ☐ **Chest X-RAY**

Result Date: _____/_____/_____ Result *(check one):* ☐ **Positive** ☐ **Negative**

Labs to be collected: ☐ BMP ☐ CMP ☐ Hepatic panel ☐ CBC w/ diff ☐ CBC w/o diff ☐ CRP ☐ ESR ☐ _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:_____

Pre-Medications:

Diphenhydramine PO or IV	25mg or 50mg	☐ Yes ☐ No
Cetirizine PO	10mg	☐ Yes ☐ No
Acetaminophen PO	650mg	☐ Yes ☐ No
Hydrocortisone IV	_____mg	☐ Yes ☐ No
Drug:_____	_____mg	

IV infliximab: ☐ **Pharmacist to select product**

☐ **Inflectra** (infliximab-dyyb) ☐ **Remicade** (infliximab-hjmt) ☐ **Renflexis** (infliximab-abda)

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ _____ mg/kg ☐ _____ mg

Frequency: ☐ Initial Dose – 0, 2, 6wks, **THEN** ☐ **q 6 wks** ☐ **q 8 wks** ☐ q _____wks

If dosing ordered other than indicated by package insert, please provide letter of medical necessity

WHEN CALCULATING DOSE: ROUND to nearest vial (100 mg per vial)
ROUND to the nearest half vial (50 mg increment)

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: ( ) _____ Office Fax Number: ( ) _____

Contact Name: _____ Contact Phone Number: ( ) _____

New referring providers, how did you hear about us?

☐ Web Search ☐ Pharma Rep ☐ Drug Locator ☐ Patient ☐ Word of Mouth ☐ IA Clinical Liaison ☐ IA Website ☐ Facebook
☐ Instagram ☐ Other: _____

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