

**BEAUMONT INFUSION CENTERS
INFLECTRA (infliximab-dyyb) PRESCRIPTION**

Location / Royal Oak : 248- 551-3168 Troy : 248-964-2409 Lenox : 947-523-4061 Wayne : 734-467-2505
 Fax Number Grosse Pointe : 586-498-4497 Farmington Hills : 248-471-8217 Dearborn : 313-593-5802 Livonia : 734-542-3356

Patient Name:		Date of Birth:	Medical Record #:
Physician Name:		Address:	Office #:
Anticipated Start Date for Care:		Diagnosis:	Diagnosis Code (ICD-10):

PATIENT INFORMATION	
Please attach these <u>required</u> documents to Prescription (if not in EPIC): <input checked="" type="checkbox"/> Copy of Insurance Card <input checked="" type="checkbox"/> Labs <input checked="" type="checkbox"/> Supporting clinical documentation <input checked="" type="checkbox"/> Patient Demographics <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies: _____	
Height: _____ Weight: _____ kg/lbs Date: _____	
REQUIRED LABS FOR THERAPY (To be completed By Physician Office) Current TB Test. Date of Test: _____ Result: _____ Hepatitis B screening completed and patient is clear to receive treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICATION	DOSE	# Doses																			
INFLECTRA (infliximab-dyyb)	_____ mg/kg x _____ kg = _____ mg (rounded to the nearest 100 mg).																				
	<input type="checkbox"/> Induction dosing at 0, 2, and 6 weeks. <input type="checkbox"/> Maintenance Dosing every _____ weeks.																				
	<input type="checkbox"/> Traditional Infusion Rate. Infuse over NO LESS THAN 2 HOURS.																				
	<table border="1" style="width:100%; border-collapse: collapse; text-align:center;"> <thead> <tr> <th>TIME (min)</th> <th>INFUSION RATE</th> <th>TIME (min)</th> <th>INFUSION RATE</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>Initiate at 10 ml/hr</td> <td>60</td> <td>Increase to 150 ml/hr</td> </tr> <tr> <td>15</td> <td>Increase to 20 ml/hr</td> <td>90</td> <td>Increase to 250 ml/hr</td> </tr> <tr> <td>30</td> <td>Increase to 40 ml/hr</td> <td>120</td> <td>End of Therapy</td> </tr> <tr> <td>45</td> <td>Increase to 80 ml/hr</td> <td></td> <td></td> </tr> </tbody> </table> <p>*For subsequent infusions: If patient tolerates infusion, may infuse over 2 hours without titration.</p>	TIME (min)	INFUSION RATE	TIME (min)	INFUSION RATE	0	Initiate at 10 ml/hr	60	Increase to 150 ml/hr	15	Increase to 20 ml/hr	90	Increase to 250 ml/hr	30	Increase to 40 ml/hr	120	End of Therapy	45	Increase to 80 ml/hr		
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	Pre Medications: <input type="checkbox"/> Acetaminophen <input type="checkbox"/> 325mg, <input type="checkbox"/> 500 mg, <input type="checkbox"/> 650 mg, <input type="checkbox"/> 1000 mg PO ½ hour prior to infusion. <input type="checkbox"/> Diphenhydramine 25mg PO ½ hour prior to infusion. <input type="checkbox"/> Methylprednisolone _____ mg IV one time only 30 minutes prior to infusion																				
	<ul style="list-style-type: none"> • 250 ml 0.9% Sodium Chloride flush bag with infusion as needed. • Adult Anaphylaxis Protocol • Notify physician if reaction occurs. 																				

Physician Signature _____ Beeper # _____ Date _____ Time _____