

Patient's Information

Date of Referral

First Name Last Name M.I.

Date of Birth

Address

City State ZIP Code

Phone

WT (kg) HT (in)

Diagnosis

Allergies

***Please fax all recent labs including TB date/results and Hepatitis B date/results.**

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

INFLECTRA DOSING

Inflectra dose of 3mg/kg IV
 Inflectra dose of 5mg/kg IV
 Inflectra dose of 10mg/kg IV
 Inflectra specific dose of

Refills:

Loading dose of day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter
 Specific dosing frequency of

Premedication of:

Prescribing Provider

Address

City State ZIP Code

Provider Signature Date/Time

Provider Phone Provider Fax