CureStat IS
Infusion Services

Phone: (888) 963-6544
Fax: (858) 281-0045
CureStatInfusions.com
Pharmacy@CureStatRx.com

INFLECTRA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB Test

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Patient Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ K51.9 (Ulcerative Colitis) ☐ K50.9 (Crohn's Disease) ☐ L40.0 (Psoriasis Vulgaris)
☐ M06.00 (Rheumatoid Arthritis w/o RF) ☐ Other: _____

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

TB/PPD test: ☐ Positive ☐ Negative **HBV:** ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

TREATMENT

INFLECTRA (infliximab-dyyb)

Route: Intravenous Infusion

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg
☐ 10mg/kg ☐ Other: ____ mg/kg

Frequency:

☐ Induction: On weeks 0, 2, and 6

☐ Maintenance: Once every ____
- ☐ 4 weeks
- ☐ 6 weeks
- ☐ 8 weeks
- ☐ Other: _____

Quantity: _____ **Refills:** ____

Premedication Protocol:

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

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

■ Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Special Instructions: _____

_____

_____

_____

Provider Signature: _____ Date: _____

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