Arthritis & Osteoporosis Center, LLC

Ivonne Herrera, MD
Sarah Fisher, PA-C
Danielle Steffan, PA-C
Gayle Whaley, MSN, AGNP-BP

1350 Middleford Road; Suite 502
Seaford, DE 19973
Phone : 302.628.8300/Fax: 302.628.8400

1324 Belmont Avenue; Unit 105
Salisbury, MD 21804
Phone: 443.944.8031/Fax: 443.944.9379

Dermatology Infusion Order

Patient name_____DOB_____

Phone number_____ Weight_____

Diagnosis_____ ICD 10 Code_____

Required testing for Infliximab HBsAg, anti-HBs, anti-HBc, QTB/PPD/T-spot

_____ Ilumya 100 mg SC at weeks 0, 4, and 12 weeks thereafter

_____ Cimzia 400 mg SC every 2 weeks x3, then every 4 weeks

_____ Infliximab (branding will follow insurance formulary protocols)

Induction ____ 3 mg/kg= _____mg IV on week 0, 2, 6

____ 5 mg/kg= _____mg IV on week 0, 2, 6

Maintenance ____ mg/kg= _____mg IV every _____ weeks

Pre Meds given PRN

___ Diphenhydramine 25mg/50mg (circle one) IV/PO ___ Solu-Medrol 40mg IV ___ Acetaminophen 650mg PO

_____ Other or additional instructions_____

_____

Is this a new treatment for this patient_____ or continuing treatment_____

Prior tried and failed medications_____

Contact person_____ Phone number_____

Name of ordering provider_____

Ordering provider signature_____ Date_____

Order valid for one year.

Please fax this information, required test, last two office notes, and insurance cards to infusion coordinator 302-613-4697. Infusion coordinator can be reached at 302-483-7053.

Additional forms may be found on our website at Arthritisde.com.