Laboratoire CERBA

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# INFLIXIMAB AND ANTI-INFLIXIMAB ANTIBODIES ASSAY

| PATIENT | PRESCRIPTEUR |
|---|---|
| ■ Name:…….. | ■ Name:…….. |
| ■ First name:…… | ■ First name:…… |
| ■ Date of birth: ⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋ | ■ Address:…… |
| ■ Gender : | ■ Tel:…… |
| | ■ Fax:…… |

## SAMPLE

Residual sample prior to new injection. Frozen serum 1ml

## INFORMATION ON SAMPLE AND INFLIXIMAB TREATMENT

■ Date of sample: ⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋

■ Molecule injected: ☐ Remicade® ☐ Inflectra® ☐ Remsima®

■ Date of the last injection: ⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋

■ Delay since the last injection: ⌊_⌋⌊_⌋ weeks

■ Last injection drug dose:

■ Number of injections aleady done: ⌊_⌋⌊_⌋

■ Indication for infliximab treatment:
……
……
……

■ Associated immunosuppressant and previous anti-TNF treatment:
……
……
……

■ Purpose of request:
……
……
……

☐ Systematic

☐ Suspicion of treatment failure

☐ Reactions related to the injection

☐ Other: please specify
……
……



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