

- Borough Park**  
1428 36th Street  
Suite 107  
Brooklyn, NY 11218
- Crown Heights**  
555 Lefferts Avenue  
Brooklyn, NY 11225
- Manhattan**  
57W 57 Street  
Suite 601  
New York, NY 10019
- Manhasset**  
333 East Shore Road  
Suite 201  
Manhasset, NY 11030
- Rockville Centre**  
165 North Village Avenue  
Suite 133  
Rockville Center, NY 11570
- Elmsford/Tarrytown**  
555 Taxter Road  
3rd Floor  
Elmsford, NY 10523
- NYC Central Park West**  
115 Central Park West  
Suite 15  
New York, NY 10028
- Woodbury**  
75 Froehlich Farm  
Woodbury, NY 11797
- Staten Island**  
27 New Dorp Lane  
Staten Island, NY 10306



- Manhattan**  
225 E 70th Street  
Suite 1E  
New York, NY 10021
- Queens**  
64-05 Yellowstone Blvd  
CF104  
Forest Hills, NY 11375
- Manhattan**  
225 East 70th Street  
New York, NY 10021
- Holbrook/Ronkonkoma**  
233 Union Ave  
Suite 207  
Holbrook, NY 11741
- Scarsdale**  
495 Central Park Avenue  
Suite 205  
Scarsdale, NY 10583
- 5 Towns**  
141 Washington Avenue  
Cedarhurst, NY 11559
- Long Beach**  
917 Beech Street  
Long Beach, NY 11561
- Riverhead**  
1228 E Main Street  
Suite A  
Riverhead, NY 11901
- Bronx**  
226 West 238th Street  
Bronx, NY 10463

# INFUSION ORDERS

# RENFLXIS (INFLIXIMAB-abda)

Date: \_\_\_\_\_

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
<input type="checkbox"/> Rheumatoid Arthritis	ICD 10 Code: M06.9
<input type="checkbox"/> Ankylosing Spondylitis	ICD 10 Code: M45.9
<input type="checkbox"/> Psoriatic Arthritis	ICD 10 Code: L40.52
<input type="checkbox"/> Plaque Psoriasis	ICD 10 Code: L40.0
<input type="checkbox"/> Other: _____	ICD10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> TB Test Results
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	
3)	

MEDICATION ORDERS	
Initial Dosing	<input type="checkbox"/> Renflexis 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Renflexis 5mg/kg IV every 8 weeks
Alternative Dosing	<input type="checkbox"/> Renflexis _____ IV every _____ weeks
Patient Weight= _____ kg	
Refills: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses	

PREMEDICATIONS	
<input type="checkbox"/> Acetaminophen 650mg PO prior to Remicade infusion <input type="checkbox"/> Diphenhydramine 25mg PO prior to Remicade infusion <input type="checkbox"/> Methylprednisolone 40mg Slow IV Push PRN infusion reaction <input type="checkbox"/> Other: _____	<b>FREQUENCY</b> <input type="checkbox"/> Week 2, 6, then every 8 weeks <input type="checkbox"/> Every 6 weeks <input type="checkbox"/> Every 8 weeks

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

## ORDERING PROVIDER

Signature   X   \_\_\_\_\_ Date \_\_\_\_\_

Provider

Phone

Fax