Philadelphia/Center City
1528 Walnut Street
Suite 1205
Philadelphia, PA 19102

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Philadelphia/King Of Prussia
216 Mall Blvd
Suite#1
King Of Prussia, PA, 19046

INFUSION ORDERS
RENFLEXIS(INFLIXIMAB-abda) Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:

DIAGNOSIS AND ICD 10 CODE

☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Rheumatoid Arthritis	ICD 10 Code: M06.9
☐ Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Plaque Psoriasis	ICD 10 Code: L40.0
☐ Other: _____	ICD10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	☐ TB Test Results

List Tried & Failed Therapies, including duration of treatment:
1)
2)
3)

MEDICATION ORDERS

Initial Dosing	☐ Renflexis 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter
Maintenance Dosing	☐ Renflexis 5mg/kg IV every 8 weeks
Alternative Dosing	☐ Renflexis _____ IV every _____ weeks

Patient Weight= _____ kg

Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses

PREMEDICATIONS

☐ Acetaminophen 650mg PO prior to Remicade infusion
☐ Diphenhydramine 25mg PO prior to Remicade infusion
☐ Methylprednisolone 40mg Slow IV Push PRN infusion reaction
☐ Other:

FREQUENCY
☐ Week 2, 6, then every 8 weeks
☐ Every 6 weeks
☐ 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