

INFUSION ORDERS

RENFLEXIS (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: _____	FREQUENCY <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