

INFUSION ORDERS RENFLEXIS (INFLIXIMAB-abda)

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

DIAGNOSIS Please provide 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 ☐ Patient demographics AND insurance information ☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody ☐ Clinical/Progress notes ☐ Labs and Tests supporting primary diagnosis ☐ TB Test Results	
List Tried & Failed Therapies, including duration of treatment: 1) _____ 2) _____ 3) _____	

RENFLEXIS ORDERS

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE:

- ☐ Renflexis 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter
☐ Renflexis 5mg/kg IV every 8 weeks
☐ Renflexis _____ IV every _____ weeks

REFILLS:

- ☐ X 6 months
☐ X 1 year
☐ _____ doses

Frequency:

- ☐ Week 2, 6, then every 8 weeks
☐ Every 6 weeks
☐ Every 8 weeks
☐ Acetaminophen 650mg PO prior to Remicade infusion
☐ Diphenhydramine 25mg PO prior to Remicade infusion
☐ Methylprednisolone 40mg Slow IV Push PRN infusion reaction
☐ Other: _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider

Phone

Fax