Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

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

Mission Medical

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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 _____