

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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 <i>Please provide ICD-10 code</i>	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: _____
☐ 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)	

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____