

TN
100 Covey Drive
Suite 307
Franklin, TN 37067

INFUSION ORDERS RENFLEXIS (INFLIXIMAB-abda)

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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 <small>Please provide ICD-10 code</small>
<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) _____

RENFLEXIS ORDERS
PATIENT WEIGHT
_____ lbs.
_____ kg
DOSAGE:
<input type="checkbox"/> Renflexis 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter
<input type="checkbox"/> Renflexis 5mg/kg IV every 8 weeks
<input type="checkbox"/> Renflexis _____ IV every _____ weeks
REFILLS:
<input type="checkbox"/> X 6 months
<input type="checkbox"/> X 1 year
<input type="checkbox"/> _____ doses
Frequency:
<input type="checkbox"/> Week 2, 6, then every 8 weeks
<input type="checkbox"/> Every 6 weeks
<input type="checkbox"/> Every 8 weeks
<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: _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____