☐ **Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ **Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225

☐ **Manhattan**
57 West 57 Street
Suite 601
New York, NY 10019

☐ **Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ **Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ **Manhattan**
225 East 70th Street
New York, NY 10021

Office: 212-803-3339 Fax : 646-768-8600
www.thrivewellinfusion.com

☐ **Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ **Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ **Holbrook/ Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ **Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ **Elmsford/ Terrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523

INFUSION ORDERS
RENFLEXIS (INFLIXIMAB-abda)

Date: ________________

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:

DIAGNOSIS AND ICD 10 CODE

Diagnosis	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	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	☐ TB Test Results

List Tried & Failed Therapies, including duration of treatment:
1)
2)
3)

MEDICATION ORDERS

Initial Dosing	☐ Renflexis 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter
Maintenance Dosing	☐ Renflexis 5mg/kg IV every 8 weeks
Alternative Dosing	☐ Renflexis _______________ IV every ______ weeks

Patient Weight= ______________ kg

Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses

PREMEDICATIONS

☐ Acetaminophen 650mg PO prior to Remicade infusion
☐ Diphenhydramine 25mg PO prior to Remicade infusion
☐ Methylprednisolone 40mg Slow IV Push PRN infusion reaction
☐ Other:

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