

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



INFUSION ORDERS RENFLXIS

(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

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

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