

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Wt(kg): \_\_\_\_\_

Allergies: \_\_\_\_\_ Phone: \_\_\_\_\_

## Renflexis (infliximab-abda) Infusion Orders

### Required Information:

Signed order from prescribing provider  
Patient demographics including insurance information  
Supporting clinical documentation: Visit notes, diagnostic results  
Required Labs: TB & Hep B screening

### Primary Diagnosis:

Crohn's Disease (ICD-10 : \_\_\_\_\_)  
Ulcerative Colitis (ICD-10: \_\_\_\_\_)  
Rheumatoid Arthritis (ICD-10 : \_\_\_\_\_)  
Psoriasis (ICD-10 : \_\_\_\_\_)  
Ankylosing Spondylitis (ICD-10 : \_\_\_\_\_)

### RENFLEXIS ORDERS

Renflexis \_\_\_\_ mg/kg

Frequency: Induction: weeks 0, 2, 6, then every 8 weeks  
Subsequent: every \_\_\_\_ weeks

Date of Last Renflexis: \_\_\_\_\_

*Administered per manufacturer guidelines*

### PRE-MEDICATIONS

PO Tylenol \_\_\_\_ mg

PO Cetirizine \_\_\_\_ mg

IV Solu-medrol \_\_\_\_ mg

PO Loratadine \_\_\_\_ mg

PO IV Diphenhydramine \_\_\_\_ mg

PO IV Other: \_\_\_\_\_ mg

### LABS

CBC

ESR

Uric Acid

Frequency:

Every Visit

CMP

TB Quantiferon Gold

Other: \_\_\_\_\_

Every Other Visit

CRP

Hep B Core/Surface AG

Other: \_\_\_\_\_

One time only

Other: \_\_\_\_\_

CPL Acct #: \_\_\_\_\_

### ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

Physician Name:

Phone:

Fax:

Physician Signature:

NPI:

Date: