

RENFLXIS (INFLIXIMAB-ABDA) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

- Rheumatoid Arthritis, ICD 10: M05.____ or M06.____ Ankylosing Spondylitis, ICD 10: M45.____
 Plaque Psoriasis, ICD 10: L40.0 Crohn's Disease, ICD 10: K50.____
 Psoriatic Arthritis, ICD 10: L40.____ Ulcerative Colitis, ICD 10: K51.____
 Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

- Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Renflexis	<input type="checkbox"/> _____ mg/kg <input type="checkbox"/> _____ mg	<input type="checkbox"/> IV	<input type="checkbox"/> Weeks 0, 2, 6 and then every 8 weeks <input type="checkbox"/> Every 8 weeks <input type="checkbox"/> Every ____ weeks

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: CT: 203.433.0621 ME: 207.407.7272 NH: 603.217.5371 NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: _____