Renflexis

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications History/Progress Notes ☐ Negative Hepatitis B within 3 years & Negative TB within 12 months.

ICD-10 CODE

DERMATOLOGY ☐ L40.5 Psoriatic Arthritis/Arthropathy ☐ L40. Psoriasis

GASTROENTEROLOGY

K50.0 Crohn's Disease, Small Intestine	K50.1 Crohn's Disease, Large Intestine	K50.8 Crohn's Disease, Small & Large Intestine
K50.9 Crohn's Disease, Unspecified	K51.8 Other Ulcerative Colitis, Chronic	K51.5 Left Sided - Ulcerative Colitis, Chronic
K51.0 Universal Ulcerative Pancolitis, Chronic	K51.9 Ulcerative Colitis, Unspecified	K60.3 Anal Fistula
K63.2 Fistula of Intestine	M05 Rheumatoid Arthritis, w/Rheumatoid Factor	M06. Rheumatoid Arthritis,w/o Rheumatoid Factor
L40.5 Psoriatic Arthritis/Arthropathy	M45. Ankylosing Spondylitis	D86.0 Sarcoidosis of the Lung

☐ Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Cetirizine (Zyrtec) ☐ 10mg PO

Loratadine (Claritin) ☐ 10mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

Hydrocortisone (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Renflexis Infuse in 250 mL of 0.9% NS over at least 2 hours via pump with 0.2-micron filter. Doses > 1000 mg need total volume of 500 mL. Medix Infusion offers Remicade at a reduced infusion time, beginning on the 4th and subsequent infusions, to patients who qualify and consent.

Loading Dose ☐ IV: Infuse 3 mg/kg at weeks 0, 2, and 6 ☐ IV: Infuse 5 mg/kg at weeks 0, 2, and 6 ☐ IV: Infuse _____ mg or _____ mg/kg at weeks 0, 2 and 6

Maintenance Dose ☐ IV: Infuse 3 mg/kg every 8 weeks for one year ☐ Infuse 5 mg/kg every 8 weeks for one year ☐ Infuse _____ mg or _____ mg/kg every week for one year

Post Treatment Observations The patient is observed for 30 minutes following the first administration.

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

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