

RENFLEXIS

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB Test

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ K51.9 (Ulcerative Colitis) ☐ K50.9 (Crohn's Disease) ☐ L40.0 (Psoriasis Vulgaris)
☐ M06.00 (Rheumatoid Arthritis w/o RF) ☐ Other: _____
Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
TB/PPD test: ☐ Positive ☐ Negative HBV: ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

TREATMENT

RENFLEXIS (infliximab-abda)

Route: Intravenous Infusion

Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg
☐ 10mg/kg ☐ Other: _____ mg/kg

Frequency:

- ☐ Induction: On weeks 0, 2, and 6
☐ Maintenance: Once every _____
☐ 4 weeks
☐ 6 weeks
☐ 8 weeks
☐ Other: _____

Quantity: _____ Refills: _____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO
☐ Other: _____

Sig: _____
☒ Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Special Instructions: _____

Provider Signature: _____

Date: _____