

# Infliximab (Renflexis)

Provider Order Form rev. 12/01/2021



## PATIENT INFORMATION

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

NKDA Allergies: \_\_\_\_\_ Weight lbs/kg: \_\_\_\_\_

**Patient Status:**  New to Therapy  Continuing Therapy Next Due Date (if applicable): \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### ICD-10 CODE

- K50.90 Crohn's Disease
- K50.90 Pediatric Crohn's Disease
- K51.90 Ulcerative Colitis
- K51.90 Pediatric Ulcerative Colitis
- M06.9 Rheumatoid Arthritis
- M45.9 Ankylosing Spondylitis
- L40.50 Psoriatic Arthritis
- L40.0 Plaque Psoriasis
- Other: \_\_\_\_\_

### MEDICATION ORDER

#### Initial/Reload Dosing:

- \_\_\_\_ mg/kg IV on day 0, 2 weeks, 6 weeks then every  6 weeks OR  8 weeks

#### Maintenance Dosing:

- \_\_\_\_ mg/kg IV every  6 weeks OR  8 weeks

## SPECIAL INSTRUCTIONS

\_\_\_\_\_  
**Provider Name (Print)** **Provider Signature** **Date**

### REQUIRED DOCUMENTATION

- Recent Office notes (along with any therapies tried and outcomes)
- Lab Results
- Insurance Cards (front and back)
- Current Medication
- Demographic Sheet
- History and Physical Report
- TB Testing

### ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ANA (SLE)
- Comprehensive Metabolic Panel, CBC with differential w/in past 3 months