Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

INFUSE ONE OHIO

(infliximab-abda)

RENFLEXIS infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis
- ☐ _____ Psoriatic Arthritis
- ☐ _____ Plaque Psoriasis
- ☐ _____ Ankylosing Spondylitis
- ☐ _____ Crohn's Disease
- ☐ _____ Ulcerative Colitis
- ☐ _____ _____

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

RENFLEXIS ORDERS

DOSAGE

- ☐ _____ mg/kg *weight-based*
- ☐ _____ mg *flat-dosed*

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

- ☐ every 0,2,6, and every 8 weeks *(induction)*
- ☐ every _____ weeks

NOTES

_____

ORDERING PROVIDER

Provider NPI: _____ Phone_____ Fax _____

Provider Name _____

Provider Address _____

Signature _____ Date_____