Renflexis
(infliximab-ABDA)

Infusion order

249 Danbury Rd. Wilton, CT 06897
400 Columbus Ave, Valhalla, NY 10595
127 Washington Ave, North Haven, CT 06473
220 Farmington Ave, Farmington, CT 06032
_____
Ph: 203-883-0038 Fax: 203-724-4838

Patient Name: _____ DOB: ____/____/_____ M F

Allergies: _____ Phone: _____

Diagnosis: _____ ICD- 10: _____

Please fax a copy of the following patient information:

☐ Recent progress Note ☐ Current CBC & CMP ☐ TB & Hep B Results *(upon initiation)*

TB test date: ____/____/_____ Result: _____ *(can be PPD skin test or QuantiFERON TB gold blood test)*
Hep B (HBsAg and anti- HBV) test date: ____/_____/_____ Result: _____

PRE- MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ No Pre-med
☐ Solu- Medrol 125mg IVP
☐ Solu- Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
Other: _____

RENFLEXIS ORDERS / IV DOSAGE

○ _____ mg/kg *weight-based* Patient Weight: _____ lbs / kg
○ _____ mg *flat-dosed* Height: _____ft_____in

FREQUENCY

○ at weeks 0, 2 and 6, then every 8 weeks *(initial)* ***OR*** ○ *every* _____ *weeks (continuation)*

NOTES:

_____

Provider's Name: _____ Signature**:** _____

NPI: _____ Date: _____ Ph: _____ Fax: _____