



# RENFLXIS (infliximab-abda)

Initial  **rral**  **Continuing Treatment**  **Medication Order Change**

**Patient Information:**

Name: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 SS#: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Physician Information:**

Referring Physician: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Fax #: \_\_\_\_\_

## Medication Orders

Patient Weight: \_\_\_\_\_ kg Patient Height: \_\_\_\_\_ inches  First Dose  Maintenance Dose

Dosing:  **LOADING DOSES:** \_\_\_\_\_ MG/KG IV @ 0 weeks, 2 weeks, 6 weeks, and then every 8 weeks

\_\_\_\_\_ MG/KG IV every \_\_\_\_\_ weeks

Premeds(if applicable):  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

Indication / Diagnosis:

- M05.\_\_\_\_ Rheumatoid arthritis
- M06.\_\_\_\_ Rheumatoid arthritis, unspecified
- L40.\_\_\_\_ Psoriatic arthritis
- M45.\_\_\_\_ Ankylosing spondylitis
- Other (please specify) \_\_\_\_\_

ICD-10 (Required) \_\_\_\_\_

**MD Signature:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Required Documentation

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

*ization completed.*

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