

Intravene – Renflexis Infusion Orders (rev 2/19/2019)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434) 455-5531 or call (434) 947-3900 ext. 3001

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Work Phone # _____
DOB _____ SSN _____
Height _____ Weight _____ lbs
Drug Allergies _____
 NKDA Sex: Male or Female

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address _____
Physician Phone(_____) _____
Physician Fax(_____) _____
NPI# _____ DEA# _____
State License# _____

****Please fax copies of insurance cards**
and this form to 434-455-5531**

DIAGNOSIS: (ICD-10 required)

- _____
- _____
- _____
- _____

Please Mark One

Patient **IS** on methotrexate **OR** Patient is **NOT** on methotrexate

PRE TREATMENT SCREENING:

Tuberculosis Screening: Date/Results of TB test _____

Hepatitis B Screening: Date/ Results: _____

Hepatitis C Screening: Date/Results: _____

STANDARD ORDERS:

Infuse Renflexis _____ mg/kg (rounded to the nearest 100mg) in Normal Saline 250ml (Total Volume) over 2 hours for 1 year. Upon completion of Renflexis treatment, infuse Normal Saline 20ml to clear line.

(Rheumatoid arthritis standard dose=3mg/kg. Crohn's disease/ulcerative colitis/ankylosing spondylitis/psoriatic arthritis/plaque psoriasis standard dose=5mg/kg

Premedication:Diphenhydramine 25mg p.o. 30 min. prior to infusion on all except first dose.

Last infusion date (if applicable): _____

FREQUENCY OF INFUSIONS:

- RHEUMATOID ARTHRITIS/CROHN'S DISEASE/ULCERATIVE COLITIS/PSORIATIC ARTHRITIS/PLAQUE PSORIASIS : 0, 2, 6 weeks, then every 8 weeks thereafter*
- ANKYLOSING SPONDYLITIS: 0, 2, 6 weeks, then every 6 weeks thereafter.*
- OTHER: _____*

LAB ORDERS:

NONE CBC EVERY _____ OTHER: _____

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

Signature, prescribing MD _____ Date _____