Phone: 608-690-7210
Fax: 608-807-5179
www.MySmartInfusion.com

Location

☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

Renflexis (Infliximab-abda)

Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90	☐ Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90	☐ Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Rheumatoid Arthritis	ICD 10 Code: M06.9	☐ Plaque Psoriasis	ICD 10 Code: L40.0

Required Labs

TB/QuantiFERON (within 12 months & attach results)
Hepatitis B Status & Date: _____
Most recent CBC & CMP (attach results)

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO
Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ **PO** ☐ **IV**
Methylprednisolone (Solu-Medrol) ☐ 125mg I**V**
Ondansetron (Zofran) ☐ 4mg ☐ **PO** ☐ **IV**
Other: _____ Route: _____
Dose: _____ Frequency: _____

Renflexis Medication Orders

Refill x12 months unless otherwise noted: _____

Patient Weight: _____ KG

Dosage

☐ 3mg/kg IV ☐ 5mg/kg IV ☐ 10mg/kg IV
☐ _____mg/kg
We will round to the nearest full vial unless checked no ☐

Frequency

☐ Induction week 0, 2, 6 then every 8 weeks

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:
- ☒ Acetaminophen 650mg PO,
- ☒ Diphenhydramine 25mg-50mg PO or IV
- ☒ Ondansetron 4mg IV
- ☒ Sodium Chloride 0.9% 1000mL IV
- ☒ Methylprednisolone 125mg IV
- ☒ Albuterol Sulfate 2.5mg nebulized
- ☒ Oxygen 1-6LPM continuous flow
- ☒ Epinephrine 0.3mg/0.3mL IM

☐ Other: _____

☒ Manage VAD per protocol:

☒ Start/Access and Discontinue PIV/CVC

☒ Flush with NS and/or Heparin per protocol based on line type
☒ Other: _____

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____