



Phone: 608-690-7210
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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
- Moderate to Severe Crohn's Disease ICD 10 Code: K50.90
- Rheumatoid Arthritis ICD 10 Code: M06.9
- Ankylosing Spondylitis ICD 10 Code: M45.9
- Psoriatic Arthritis ICD 10 Code: L40.52
- 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 IV

Ondansetron (Zofran) 4mg 8mg 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.

<input checked="" type="checkbox"/> Administer the following emergency medications per Smart Infusion Therapy Services protocol: <input checked="" type="checkbox"/> Acetaminophen 650mg PO, <input checked="" type="checkbox"/> Diphenhydramine 25mg-50mg PO or IV <input checked="" type="checkbox"/> Ondansetron 4mg IV <input checked="" type="checkbox"/> Sodium Chloride 0.9% 1000mL IV <input checked="" type="checkbox"/> Methylprednisolone 125mg IV <input checked="" type="checkbox"/> Albuterol Sulfate 2.5mg nebulized <input checked="" type="checkbox"/> Oxygen 1-6LPM continuous flow <input checked="" type="checkbox"/> Epinephrine 0.3mg/0.3mL IM	<input checked="" type="checkbox"/> Manage VAD per protocol: <input checked="" type="checkbox"/> Start/Access and Discontinue PIV/CVC <input checked="" type="checkbox"/> Flush with NS and/or Heparin per protocol based on line type <input checked="" type="checkbox"/> Other: _____
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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: _____