

RENFLEXIS (INFLIXIMAB-ABDA) IV INFUSION ORDER FORM

Full Name: Date of Birth:

Phone Number: Email Address:

Address:

Weight: lb/kg Allergies: ☐ NKDA ☐

Treatment Status: ☐ New ☐ Continued **Last Treatment Date:**

DIAGNOSIS (ICD-10 SELECTION)

☐ K50.90 – Crohn's disease, unspecified ☐ M45.9 – Ankylosing spondylitis

☐ K51.90 – Ulcerative colitis, unspecified ☐ L40.52 – Psoriatic arthritis

☐ M06.9 – Rheumatoid arthritis, unspecified ☐ L40.0 – Plaque psoriasis ☐ D86.0 – Sarcoidosis of lung

☐ Other: ☐ ICD-10 CODE:

INFUSION ORDER

Induction Phase:

- ☐ 3 mg/kg IV at Weeks 0, 2, and 6
- ☐ 5 mg/kg IV at Weeks 0, 2, and 6

Maintenance Phase:

- ☐ 3 mg/kg IV every 8 weeks
- ☐ 5 mg/kg IV every 8 weeks
- ☐ Other: mg/kg IV every weeks
- ☐ Infuse in 250 mL 0.9% sodium chloride over ≥2 hours using 0.2-micron filter
- ☐ Observation: ☐ 30 minutes post-infusion
- ☐ Refills: ☐ None ☐ 6 months ☐ 12 months ☐ Other:

LINE USE & ACCESS

- ☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard injection protocol

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Kaison Infusion Center Protocol (www.kaisoninfusion.com)
- ☐ Other - please fax preferred reaction orders to (405) 237-6305

PREMEDICATION (OPTIONAL)

☐ Acetaminophen:	☐ 650 mg	☐ PO	
☐ Diphenhydramine:	☐ 25 mg	☐ 50 mg	☐ PO ☐ IV
☐ Methylprednisolone:	☐ 125 mg	☐ IV	
☐ Cetirizine:	☐ 10 mg	☐ PO	
☐ Famotidine:	☐ 20 mg	☐ IV	
☐ Other:	Dose:	Route:	

LABORATORY MONITORING

- ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ TB Screening ☐ Hepatitis B Panel ☐ Other:
- Frequency:** ☐ Prior to first dose ☐ Every infusion ☐ Monthly ☐ Other:
- ☐ Physician office will order labs only

CLINICAL DOCUMENTATION CHECKLIST

- ☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
- ☐ Documentation of prior DMARD or biologic therapy

ORDERING PROVIDER & DEMOGRAPHICS

Name: NPI: LICENSE #:

Contact: Phone: Fax:

Email: Signature: Date: