

RENFLEXIS®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMA	TION		
Name: DOB:		Prescriber Name:			
Address:			State License:		
City, State, Zip:			NPI #: DEA:		
Phone: Alt. Phone:					
Email: SS#:				Fax:	
Gender: M F Weight:(lbs) Ht:				Phone:	
INSURANCE INFORMATION – AND – Send a copy of the patier					
Primary Insurance:			RX Card (PBM):		
City, State, Zip:				PCN:	
Plan #: Group #:			City, State, Zip:		
			Group #: Phone:		
CLINICAL INFORMATION					
□ K51.90 Moderate to Severe Ulcerative Colitis			*If PPD test results are not within 12 months, please perform PPD.		
□ K50.90 Moderate to Severe Crohn's Disease			Tuberculosis Screening: PPD Test Date:		
M06.9 Rheumatoid Arthritis			Results: 🗆 Negative		
M45.9 Ankylosing Spondylit	is		$\square \text{ Positive } \rightarrow \square \text{ Chest X-Ray Performed Date: } \$		
L40.52 Psoriatic Arthritis			X-Ray Results: Negative X-Ray Results:		
🗆 L40.0 Plaque Psoriasis			\square Positive \rightarrow TB treatment Initiated		
□ Other:					
Labs:					
□ CBC q: □ CMP q	: 🗆 CRP q: 🗆 I	ESR q:	🗆 LFTs q:	□ X-Ray: □ Other:	
RENFLEXIS® ORDERS					
Prescription type: 🗌 New star	rt 🗌 Restart 🗌 Continued there	ару	Total Doses Received:	Date of Last Infusion:	
Medication	Direc	tions		Quantity/Refills	
	Loading dose: 5mg/kg	mg IV at week: 0, 2, 6		Loading dose: 3 doses. No refills.	
Renflexis [®] (infliximab-abda)] 3mg/kg mg IV at week: 0, 2, 6		' at week: 0, 2, 6	Maintenance dose: 8-week supply. Refill x 1 year unless noted otherwise.	
Refineris [®] (infinitinal-abua)] Other:		week supply		
	Maintenance dose: (mg/kg) mg		mg IV every	every Refill x 1 year unless noted otherwise.	
	weeks			□ Other:	
Pre-Medication	Dose/Strength		I	Directions	
Acetaminophen	🗆 500mg 🗆 Tak		ke 1-2 tablets PO prior to infusion or post-infusion as directed		
	□ 25mg IV/PO	🗆 Tak	ke 1 tablet PO prior to infusion or as directed OR		
Diphenhydramine	□ 50mg IV/PO	🗆 Inje	ect contents of 1 vial IV prior to infusion or as directed		
	□ 40mg □ 100mg	🗆 Inje	ject contents of 1 vial IV prior to infusion or as directed		
Methylprednisolone	□ 125mg	🗆 Otł	Other: Inject 100mg IV 30 minutes prior to infusion		
□					
INFUSION REACTION ORI	DERS				
Mild reaction protocol:					

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☑ Diphenhydramine 25mg IV, one time, for pruritus.							
If symptoms worsen, see orders for moderate to se	evere reactions.						
Moderate reaction protocol:							
Acetaminophen 650mg PO, one time, for pyrexia or rigors							
⊠ Diphenhydramine 50mg IV, one time, for pruritus or urticaria							
⊠ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms							
If symptoms worsen, see interventions for severe reactions							
Severe reaction protocol: (Call 911 if initiated):							
Itrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)							
☑ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis							
Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis							
Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms							
Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or							
worsen							
FLUSHING & LOCKING ORDERS							
Flushing Protocol (>66lbs/33kg)							
1 10511115 1 1010001 (* 00103) 331(B)		-					
PIV and Midline:		Implanted Port, PICC, T	unneled Catheter, and Non-tunneled Catheter:				
	d after each infusion	•	e 5mL IV flush before infusion/lab draw and 10mL				
PIV and Midline:	d after each infusion	🗵 0.9% Sodium Chlorid	e 5mL IV flush before infusion/lab draw and 10mL				
PIV and Midline: ⊠ 0.9% Sodium Chloride 2-5mL IV flush before an	d after each infusion PICC:	🗵 0.9% Sodium Chlorid	e 5mL IV flush before infusion/lab draw and 10mL				
PIV and Midline: ⊠ 0.9% Sodium Chloride 2-5mL IV flush before an Locking Protocol (>66lbs/33kg)		 ☑ 0.9% Sodium Chlorid Ⅳ flush after infusion/la 	e 5mL IV flush before infusion/lab draw and 10mL b draw				
 PIV and Midline: ☑ 0.9% Sodium Chloride 2-5mL IV flush before an Locking Protocol (>66lbs/33kg) PIV and Midline: 	PICC:	0.9% Sodium Chlorid IV flush after infusion/la nits/mL 3mL IV final	e 5mL IV flush before infusion/lab draw and 10mL b draw Implanted Port, Tunneled Catheter, and Non-				
 PIV and Midline: ☑ 0.9% Sodium Chloride 2-5mL IV flush before an Locking Protocol (>66lbs/33kg) PIV and Midline: ☑ Heparin Sodium 10 units/mL 1mL IV final 	PICC: ⊠ Heparin Sodium 10 u	0.9% Sodium Chlorid IV flush after infusion/la nits/mL 3mL IV final	e 5mL IV flush before infusion/lab draw and 10mL b draw Implanted Port, Tunneled Catheter, and Non- tunneled Catheter:				
 PIV and Midline: ☑ 0.9% Sodium Chloride 2-5mL IV flush before an Locking Protocol (>66lbs/33kg) PIV and Midline: ☑ Heparin Sodium 10 units/mL 1mL IV final 	PICC: ☑ Heparin Sodium 10 u flush post normal saline	☑ 0.9% Sodium Chlorid IV flush after infusion/la nits/mL 3mL IV final flush	e 5mL IV flush before infusion/lab draw and 10mL b draw Implanted Port, Tunneled Catheter, and Non- tunneled Catheter: ⊠ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush				
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 PIV and Midline: ☑ 0.9% Sodium Chloride 2-5mL IV flush before an Locking Protocol (>66lbs/33kg) PIV and Midline: ☑ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush ** May substitute Dextrose 5% in Water, or alternative SIGNATURE We hereby authorize Talis Healthcare LLC to provise medicine as prescribed in this referral 	PICC: ☑ Heparin Sodium 10 u flush post normal saline , for 0.9& Sodium Chloride, v	☑ 0.9% Sodium Chlorid IV flush after infusion/la nits/mL 3mL IV final flush	e 5mL IV flush before infusion/lab draw and 10mL b draw Implanted Port, Tunneled Catheter, and Non- tunneled Catheter: ☑ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush patibility with medications bring infused				
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To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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