FUSE INFUSION
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New Rochelle, NY
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(infliximab-abda)

# RENFLEXIS infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

## DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis
- ☐ _____ Psoriatic Arthritis
- ☐ _____ Plaque Psoriasis
- ☐ _____ Ankylosing Spondylitis
- ☐ _____ Crohn's Disease
- ☐ _____ Ulcerative Colitis
- ☐ _____ _____

## PRE-MEDICATION

- ☐ Tylenol 1000mg IV
- ☐ Diphenhydramine 25mg IV
- ☐ Cetirizine 10mg IV
- ☐ _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

## RENFLEXIS ORDERS

### DOSAGE

- ○ _____ mg/kg *weight-based*
- ○ _____ mg *flat-dosed*

### PATIENT WEIGHT

_____ lbs.

_____ kg

### FREQUENCY

- ○ every 0,2,6, and every 8 weeks *(induction)*
- ○ every _____ weeks

## NOTES

_____

## ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____