



RENFLEXIS (infliximab-abda) infusion orders

Patient Name _____ DOB _____
Phone _____ M _____ F _____

DIAGNOSIS *Please provide ICD-10 code*

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

PRE-MEDICATION

Tylenol 1000mg PO	Solu-Medrol 125mg IVP
Diphenhydramine 25mg PO	Solu-Cortef 100mg IVP
Cetirizine 10mg PO	Diphenhydramine 25mg IVP

RENFLEXIS ORDERS

DOSAGE	PATIENT WEIGHT
mg/kg <i>weight-based</i>	lbs.
mg <i>flat-dosed</i>	kg
FREQUENCY	
every 0,2,6, and every 8 weeks <i>(induction)</i>	
every _____ weeks	

NOTES

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____