

Renflexis



Ph: 518-782-3899 | Fax: 518-782-3884

Date: \_\_\_\_\_

Please include the following to expedite the order

Demographics, Insurance Information, Current CBC & CMP, Last Progress Note Relevant to the Diagnosis, Current Medications, Previous Medications, Viral Hepatitis Results, TB Results, Written Informed Consent

**PATIENT INFORMATION**

**PRESCRIBER INFORMATION**

Patient Name: \_\_\_\_\_

Prescriber's Name: \_\_\_\_\_

Patient Contact Number: \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Allergies: \_\_\_\_\_

Office Address: \_\_\_\_\_

Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Contact Email: \_\_\_\_\_

ICD 10: \_\_\_\_\_

Please check this box if you **DO NOT** authorize InfusionCare to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

**PREMEDS**

No Premeds

Benadryl:  PO  IV  25 mg  50 mg

Acetaminophen:  PO  650 mg  Other: \_\_\_\_\_

Methylprednisolone:  IV  \_\_\_\_\_ mg

Other: \_\_\_\_\_

You authorize InfusionCare to utilize the hypersensitivity protocol established by InfusionCare.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## RENFLEXIS DOSAGE

Date of Last Treatment, if Continuation: \_\_\_\_\_

Route:  IV

\_\_\_\_\_ mg/kg

Loading Frequency                      0, 2, 6 weeks

Maintenance                                  Every  \_\_\_\_\_ weeks

Rapid infusion over one hour after first maintenance infusion

Refills:  3 months                       6 months

(if not indicated order will expire 6 months from date signed)

***To ensure that a Brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, InfusionCare is authorized to administer generic or biosimilar.***

## LAB ORDERS

No Labs

List: \_\_\_\_\_

Frequency: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_