

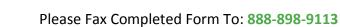
RENFLEXIS®

Please Fax Completed Form To: 888-898-9113

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION		
Name: DOB:		Prescriber Name:		
Address:		State License:		
City, State, Zip:		NPI #: DEA:		
Phone: Alt. Phone:				
Email: SS#:				
Gender: 🗆 M 🗆 F Weight:(lbs) Ht:			Fax:	
Allergies:		Office Contact:	Phone:	
INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)				
Primary Insurance:		RX Card (PBM):		
City, State, Zip:			PCN:	
Plan #:		City, State, Zip:		
Group #:		Group #:		
Phone:		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		Tuberculosis Screening: PPD Test Date:		
□ M06.9 Rheumatoid Arthritis		Results: Regative		
□ M45.9 Ankylosing Spondylitis				
L40.52 Psoriatic Arthritis		□ Positive \rightarrow □ Chest X-Ray Performed Date:		
L40.0 Plaque Psoriasis		X-Ray Results: Negative		
□ Other:		\Box Positive \rightarrow TB treatment Initiated		
Labs:				
□ CBC q: □ CMP c	ı: □ CRP q: □ ESR q:	LFTs q:	□ X-Ray: □ Other:	
RENFLEXIS® ORDERS				
Prescription type: 🛛 New sta	rt 🛛 Restart 🗌 Continued therapy	Total Doses Received:	Date of Last Infusion:	
Medication	Directions		Quantity/Refills	
	Loading dose: 🗆 5mg/kg mg 🛚	/ at week: 0. 2. 6	Loading dose: 3 doses. No refills.	
	□ 3mg/kg mg I\		Maintenance dose: 8-week supply. Refill x 1	
Renflexis [®] (infliximab-abda)			year unless noted otherwise.	
	□ Other:		week supply	
	□ Maintenance dose: (mg/kg) weeks	mg IV every	Refill x 1 year unless noted otherwise.	
PRE-MEDICATIONS				
□ Diphenhydraminemg, □ PO -or- □ IV, prior to start of infusion □ Acetaminophen 650 mg PO prior to start of infusion				
□ Prednisonemg, PO -or- □ Methylprednisolone 40 mg IVP -or- □ Hydrocortisone 100 mg IVP				
\Box Other:				
ANAPHYLACTIC REACTION (AR):				
□ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary				
\Box EpiPen Jr [®] Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary				
Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary				
□ Hydrocortisone 100mg - Give 100 mg IVP -or- IM if no IV access				
□ Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr				
□ Other:				

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

RENFLEXIS®



IV ACCESS				
\Box Start PIV if no IV access available \Box Maintain current central line access				
MONITORING PARAMETERS				
\Box Obtain vital signs and temperature every 15 mins for the 1st hour, then every 30 mins for the remainder of the infusion				
\Box Observe patient for 30 mins following the infusion				
\Box Instruct patient to report symptoms of chills, fever, headache, sore throat, pain, etc.				
□ Other:				
CATHETER CARE				
\Box Sodium Chloride 0.9% mL IV before and after each IV access and PRN per protocol				
Sodium Chloride 0.9% mL as above AND Heparin 100 Units /mL mL IV flush after second saline flush and PRN				
Dressing changes weekly and PRN Antimicrobial dressing PRN				
🗌 May obtain blood from IV access for labs 🛛 🗌 May use Cathflo 2 mg/2 mL sterile water IVP 2 mL per lumen; May repeat after 2 hours x 1				
STANDARD ORDER FOR SIDE EFFECTS				
\Box Promethazine 25 mg – 1-2 tabs po q 4-6 hrs PRN nausea / vomiting	Diphenhydramine 25 mg - 1 to 2 caps po PRN			
\Box Acetaminophen 325 mg - 2 tabs po q 4-6 hrs PRN HA, myalgia, fever	□ Diphenhydramine 25 mg -or- 50 mg IV x 1 dose PRN			
\Box Promethazine 25 mg IV/IM x 1 dose PRN nausea / vomiting	Other:			
SIGNATURE				
We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral				
x	Date:			
Prescriber Signature				

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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