PURE INFUSION SUITES

INFUSION ORDERS RENFLEXIS
(biosimilar to remicade)

Fax form to:
o ora o r o
ra t o Fa
o r
F o ta r r at Fa
F a o a t a t 801.852.0999

Note: you must enter a 1 before the fax number

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

***Please fax all recent labs including TB date/results and Hepatitis B date/results.**

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval**

FOLLOWS REMICADE DOSING

- ☐ Renflexis dose of 3mg/kg IV
- ☐ Renflexis dose of 5mg/kg IV
- ☐ Renflexis dose of 10mg/kg IV
- ☐ Renflexis specific dose of

Refills:

Frequency

- ☐ Loading dose of day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter
- ☐ Specific dosing frequency of

Premedications

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature | Date

Provider Phone | Provider Fax