



Remicade (infliximab) Patient Referral and Prescription Sheet
Return Signed Rx via Fax to: 877.445.8821

Date:	To:	From:	
Phone:	Fax:	Number of Pages:	

Patient Information

Patient Name:	DOB:	Height:
Allergies:	Weight:	

Medication Order

Remicade® (infliximab) **Inflectra® (infliximab-dyyb)** **Renflexis® (infliximab-abda)** **Avsola™ (infliximab-axxq)**

_____ mg x _____ kg = _____ IV at 0, 2, 6, and then every 8 weeks for _____ courses

Dose will be rounded to the nearest vial size

Reconstitute each vial with 10 mL Sterile Water then dilute with 250 mL Normal Saline.
 Administer for at least 2 hours with an in-line filter.

Refills

Diagnosis	ICD-10	Diagnosis	ICD-10
<input type="checkbox"/> Ankylosing spondylitis	M45	<input type="checkbox"/> Rheumatoid arthritis	M06.9
<input type="checkbox"/> Crohn's Disease	K50.90	<input type="checkbox"/> Ulcerative colitis	K51.90
<input type="checkbox"/> Plaque psoriasis	L40.0	Other:	
<input type="checkbox"/> Psoriatic arthritis	L40.52		

IV Access Device: Peripheral Central **Lab order:** CBC with diff CMP _____

Pre-medications:	If applicable, flush IV access device per KabaFusion protocol:		
<input type="checkbox"/> Diphenhydramine: _____ <input type="checkbox"/> PO <input type="checkbox"/> IV	Access	NS	Heparin
<input type="checkbox"/> Acetaminophen: _____ <input type="checkbox"/> PO <input type="checkbox"/> IV	Peripheral	1-3 mL before/after use	10 U/mL 1-2 mL after last NS flush
<input type="checkbox"/> Methylprednisolone: _____ <input type="checkbox"/> IV	Midline, Central (non-port), PICC	5-10 ml before/after use 5-20 ml after blood draw	10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw
<input type="checkbox"/> Other pre-meds: _____	Implanted Port	5-10 mL before/after use. 20mL after blood draw	100 U/mL 5 mL after last NS flush 5 mL after the blood draw
<input type="checkbox"/> Hydration: Infuse 500 mL of Normal Saline with Infliximab infusion	Tunneled	5-10 mL before/after use 20mL after blood draw	10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw
<input type="checkbox"/> Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack: <u>Adult:</u> 0.3 mg <u>Children:</u> 0.15 mg Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. Refill x 1yr	Groshong PICC, Midline	5-10 mL before/after use 10 mL after blood draw	None

I authorize KabaFusion and its representatives to act as an agent and initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion.

Prescriber Signature: _____ Date: _____

Print Prescriber Name: _____ NPI#: _____

DOCUMENTATION – PLEASE FAX TO KABAFUSION

- Rx Order** – include dose, route of administration, frequency, duration, & pre-medications OR use the Rx order form above
- Patient Demographics** – include **insurance** information. We will obtain authorization unless the insurance dictates otherwise.
- H & P OR progress note(s)** describing diagnosis, clinical status, and clinical symptoms.
- TB and Hepatitis B Virus (HBV) screening results** (required prior to Remicade initiation) – **HBsAg and anti-HBc.**
- Most recent lab results for: **BUN/Creatinine** (preferred within last 90 days), **CMP Panel and CBC with Differential**

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