KabaFusion
Patient-Focused Infusion Therapy

Remicade (infliximab) Patient Referral and Prescription Sheet

Return Signed Rx via Fax to: 407.425.7445

Date:	To:	From:
Phone: **407.425.7114**	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
❒ Ankylosing spondylitis	M45	❒ Rheumatoid arthritis	M06.9
❒ Crohn's Disease	K50.90	❒ Ulcerative colitis	K51.90
❒ Plaque psoriasis	L40.0	Other:	
❒ Psoriatic arthritis	L40.52		

IV Access Device: ❒ Peripheral ❒ Central

Lab order: ❒ CBC with diff ❒ CMP ❒ ___________________

Pre-medications:

❒ Diphenhydramine: _________ ❒ PO ❒ IV
❒ Acetaminophen: ___________ ❒ PO ❒ IV
❒ Methylprednisolone: ____________ ❒ IV
❒ Other pre-meds: __________________________
❒ **Hydration:** Infuse 500 mL of Normal Saline with Infliximab infusion
❒ **Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack:**
Adult: 0.3 mg Children: 0.15 mg
Administer epinephrine IM in the event of anaphylaxis.
May repeat x 1 as needed, Call 911. **Refill x 1yr**

If applicable, flush IV access device per KabaFusion protocol:

Access	NS	Heparin
Peripheral	1-3 mL before/after use	10 U/mL 1-2 mL after last NS flush
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
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
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
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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