



Prescriber Signature: _

Remicade (Infliximab) Patient Referral and Prescription Sheet

Patient Information									
Patient Name:					Date:				
DOB:					Height:	Height:		☐ inches ☐ cm	
Allergies:					Weight: ☐ Ibs ☐ kg				
Primary Diagnosis									
Diagnosis ICD-10				Diagnosis ICD-10				ICD-10	
☐ Crohn's Disease of small intestine without complications K50.00				☐ Crohn's Disease of large intestine without complications K5				K50.10	
☐ Crohn's Disease, unspecified without complications K50.90				☐ Ulcerative Chronic pancolitis without complications K51.00				K51.00	
☐ Plaque Psoriasis		L40.0	☐ Psoriatic Psoriasis L40.52				L40.52		
☐ Rheumatoid arth		M06.9	☐ Ankylosing Spondylitis M45.9				M45.9		
☐ Ulcerative Colitis	nout complications	K51.90	☐ Other						
Medication Order									
☐ Remicade	☐ Avsola	☐ Infliximab	☐ Inflectra ☐ Zymfentra ☐ Refills x one year						
Dosing: ☐ Initiation: Administer mg/kg IV over at least two hours at weeks 0, 2 and 6 per protocol ☐ Maintenance: Administer mg/kg IV over minutes every weeks ☐ Round to the nearest 100mg vial size OR exact dose of: mg ☐ 120mg SC every 2 weeks ☐ Other Other Other									
Nursing Orders Skilled nursing visit for clinical assessment, administration of medication. Initiate plan of treatment for ongoing nursing services. Insert or access and maintain access device as indicated in Ancillary Orders. Remove peripheral IV or access from implanted VAD when infusion is completed.									
Ancillary Orders									
Pre-medications: ☐ Diphenhydraming ☐ Acetaminophen: ☐ Famotidine: 20 m ☐ Other pre-meds: ☐ Refill x one year	650mg PO 30 mi ng PO x1 dose	IV Flush Orders: ☐ Peripheral: NS 1-3 mL before/after use ☐ Implanted VAD: NS 5 to 10 mL before/after use and 10 mL postlab draw. Heparin (100 unit/mL) 3 to 5 mL final flush ☐ CVAD: NS 5 to 10 mL before/after use and 10 mL postlab draw Heparin (10 units/mL) 3 to 5 mL final flush ☐ Refill x one year							
☐ Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack: Adult: 0.3mg Children: 0.15 mg Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. Refill x 1yr									
Therapy Specific Documentation				Other Required Documentation					
Please include the following lab results CMP CBC LFTS CRP Infliximab Trough Levels Other				 □ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise. □ H & P OR progress note(s) □ Medication List- Please list past and present DMARDS/biologics below with dates of discontinue, if applicable □ Hepatitis B Surface Antigen □ Hepatitis B Core Antibody Total (not Core IgM) □ QuantiFERON-TB Gold 					
Provider Information									
Provider Name:			Provider Phone:	rovider Phone:					
Provider NPI:			rovider Fax:						
Provider Address:									
Lauthorize KahaFusion and	its representatives to	act as an agent and initia	ate and execute any insurar	nce prior authoriza	tion process for this prescription	and any futi	ire refills of the san	ne prescription	
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 refills of the same prescription or the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion.									

CONFIDENTIALITY NOTICE: The following includes confidential, proprietary information that is the sole exclusive property of KabaFusion Holdings, LLC. No rights in, relating to, or derived from such information are assigned or otherwise transferred by this document, and the recipient of such information is subject to obligations of secrecy to and for the benefit of KabaFusion Holdings, LLC. Any unauthorized use or disclosure of such information is strictly prohibited. This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination, or copying of this message, or any attachment, is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return fax and shred this document along with any other documents. Thank you.

Date: __