KabaFusion
Patient-Focused Infusion Therapy

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# Remicade (Infliximab) Patient Referral and Prescription Sheet

| Patient Information | | |
|---|---|---|
| **Patient Name:** | **Date:** | |
| **DOB:** | **Height:** | ❑ **inches** ❑ **cm** |
| **Allergies:** | **Weight:** | ❑ **lbs** ❑ **kg** |

| Primary Diagnosis | | | |
|---|---|---|---|
| **Diagnosis** | **ICD-10** | **Diagnosis** | **ICD-10** |
| ❑ Crohn's Disease of small intestine without complications | K50.00 | ❑ Crohn's Disease of large intestine without complications | K50.10 |
| ❑ Crohn's Disease, unspecified without complications | K50.90 | ❑ Ulcerative Chronic pancolitis without complications | K51.00 |
| ❑ Plaque Psoriasis | L40.0 | ❑ Psoriatic Psoriasis | L40.52 |
| ❑ Rheumatoid arthritis, unspecified | M06.9 | ❑ Ankylosing Spondylitis | M45.9 |
| ❑ Ulcerative Colitis, unspecified without complications | K51.90 | ❑ Other | |

## Medication Order

❑ **Remicade** ❑ **Renflexis** ❑ **Avsola** ❑ **Infliximab** ❑ **Inflectra** ❑ **Zymfentra**

**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 _____

❑ Refills x one year from date of signature unless indicated below

❑ _____ **Refills**

**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:**
❑ Diphenhydramine: 25mg PO 30 min pre-infusion
❑ Acetaminophen: 650mg PO 30 min pre-infusion
❑ Famotidine: 20 mg PO x1 dose
❑ Other pre-meds: _____
❑ **Refill x one year**

**IV Flush Orders:**
❑ Peripheral: NS 1-3 mL before/after use
❑ Implanted VAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw. Heparin (100 unit/mL) 3 to 5 mL final flush
❑ CVAD: NS 5 to 10 mL before/after use and 10 mL post-lab 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** | ❑ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise. |
| ❑ CMP<br>❑ CBC<br>❑ LFTs<br>❑ CRP<br>❑ Infliximab Trough Levels<br>❑ Other _____ | ❑ H & P OR progress note(s)<br>❑ Medication List- Please list past and present DMARDS/biologics below with dates of discontinue, if applicable<br>❑ Hepatitis B Surface Antigen<br>❑ Hepatitis B Core Antibody Total (not Core IgM)<br>❑ QuantiFERON-TB Gold |

| Provider Information | |
|---|---|
| **Provider Name:** | **Provider Phone:** |
| **Provider NPI:** | **Provider Fax:** |
| **Provider Address:** | |

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 refills 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: _____



Last Updated: 05/2025