

## Remicade (Infliximab) Patient Referral and Prescription Sheet

Patient Information			
<b>Patient Name:</b>		<b>Date:</b>	
<b>DOB:</b>		<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm
<b>Allergies:</b>		<b>Weight:</b>	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Primary Diagnosis			
<b>Diagnosis</b>	<b>ICD-10</b>	<b>Diagnosis</b>	<b>ICD-10</b>
<input type="checkbox"/> Crohn's Disease of small intestine without complications	K50.00	<input type="checkbox"/> Crohn's Disease of large intestine without complications	K50.10
<input type="checkbox"/> Crohn's Disease, unspecified without complications	K50.90	<input type="checkbox"/> Ulcerative Chronic pancolitis without complications	K51.00
<input type="checkbox"/> Plaque Psoriasis	L40.0	<input type="checkbox"/> Psoriatic Psoriasis	L40.52
<input type="checkbox"/> Rheumatoid arthritis, unspecified	M06.9	<input type="checkbox"/> Ankylosing Spondylitis	M45.9
<input type="checkbox"/> Ulcerative Colitis, unspecified without complications	K51.90	<input type="checkbox"/> Other	
Medication Order			
<input type="checkbox"/> <b>Remicade</b> <input type="checkbox"/> <b>Renflexis</b> <input type="checkbox"/> <b>Avsola</b> <input type="checkbox"/> <b>Infliximab</b> <input type="checkbox"/> <b>Inflectra</b> <input type="checkbox"/> <b>Zymfentra</b>			<input type="checkbox"/> Refills x one year from date of signature unless indicated below  <input type="checkbox"/> _____ Refills
<b>Dosing:</b> <input type="checkbox"/> Initiation: Administer _____ mg/kg IV over at least two hours at weeks 0, 2 and 6 per protocol <input type="checkbox"/> Maintenance: Administer _____ mg/kg IV over _____ minutes every _____ weeks <input type="checkbox"/> Round to the nearest 100mg vial size OR exact dose of: _____ mg <input type="checkbox"/> 120mg SC every 2 weeks <input type="checkbox"/> Other _____			
<b>Nursing Orders</b> 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			
<b>Pre-medications:</b> <input type="checkbox"/> Diphenhydramine: 25mg PO 30 min pre-infusion <input type="checkbox"/> Acetaminophen: 650mg PO 30 min pre-infusion <input type="checkbox"/> Famotidine: 20 mg PO x1 dose <input type="checkbox"/> Other pre-meds: _____ <input type="checkbox"/> <b>Refill x one year</b>		<b>IV Flush Orders:</b> <input type="checkbox"/> Peripheral: NS 1-3 mL before/after use <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> <b>Refill x one year</b>	
<input type="checkbox"/> <b>Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack:</b> Adult: 0.3mg Children: 0.15 mg Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. <b>Refill x 1yr</b>			
Therapy Specific Documentation		Other Required Documentation	
<b>Please include the following lab results</b>  <input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> LFTs <input type="checkbox"/> CRP <input type="checkbox"/> Infliximab Trough Levels <input type="checkbox"/> Other _____		<input type="checkbox"/> Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise. <input type="checkbox"/> H & P OR progress note(s) <input type="checkbox"/> Medication List- Please list past and present DMARDS/biologics below with dates of discontinue, if applicable <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis B Core Antibody Total (not Core IgM) <input type="checkbox"/> QuantiFERON-TB Gold	
Provider Information			
<b>Provider Name:</b>		<b>Provider Phone:</b>	
<b>Provider NPI:</b>		<b>Provider Fax:</b>	
<b>Provider Address:</b>			

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: \_\_\_\_\_

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