



Prescriber Signature: _

Remicade (Infliximab) Patient Referral and Prescription Sheet

Reinicade (Infilatinab) Latient Referrar and Frescription Sheet								
Patient Information								
Patient Name:					Date:			
DOB:					Height:	Height: ☐ inches ☐		cm
Allergies:					Weight:	Weight: ☐ lbs ☐ kg		
Primary Diagnosis								
Diagnosis		Diagnosis				ICD-10		
☐ Crohn's Disease o	of small intestine w	☐ Crohn's Disease of large intestine without complications				K50.10		
☐ Crohn's Disease, unspecified without complications K50.90				☐ Ulcerative Chronic pancolitis without complications K5				K51.00
☐ Plaque Psoriasis L40.0				☐ Psoriatic Psoriasis L4				L40.52
☐ Rheumatoid arthritis, unspecified M06.9				☐ Ankylosing Spondylitis				M45.9
☐ Ulcerative Colitis,	unspecified with	□ Other						
Medication Order								
☐ Remicade	☐ Renflexis	☐ Avsola	☐ Infliximab	☐ Inflectra	☐ Zymfentra	☐ Refi	lls 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						from date of signature unless indicated below Refills		
☐ 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: ☐ Diphenhydramine ☐ Acetaminophen: ☐ Famotidine: 20 m ☐ Other pre-meds: ☐ Refill x one year	650mg PO 30 min 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 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	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:			
Provider NPI:			Provider Fax:					
Provider Address:								
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.								

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Date: __