

Prescriber Signature: _

Remicade (Infliximab) Patient Referral and Prescription Sheet

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Patient Information											
Patient Name:							Date:				
DOB:						Height:			☐ inches ☐ cm		
Allergies:						Weight:			☐ lbs ☐ kg		
Primary Diagnosis											
Diagnosis ICD-10					Diagnosis ICD-					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 arth) 🔲 An	☐ Ankylosing Spondylitis					M45.9				
☐ Ulcerative Colitis, unspecified without complications K51.90					□ Other						
Medication Order											
☐ Remicade	nicade 🔲 Renflexis 🗀 Avsola 🔲 Infliximab 🗀 Inflectra 🗀 Zymfentra 🗀 Refills x one yo							lls x one year			
Dosing:						from date of					
☐ Initiation: Administer mg/kg IV over at least two hours at weeks 0, 2 and 6 per protocol signature unless											
☐ Maintenance: Administermg/kg IV over minutes every weeks indicated below ☐ Round to the nearest 100mg vial size OR exact dose of:mg											
120mm CC event 2 vessle									Refills		
Other									Keiiiis		
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:					IV Flush Orders:						
☐ Diphenhydramine: 25mg PO 30 min pre-infusion☐ Acetaminophen: 650mg PO 30 min pre-infusion					☐ Peripheral: NS 1-3 mL before/after use ☐ Implanted VAD: NS 5 to 10 mL before/after use and 10 mL post-						
☐ Famotidine: 20 mg PO x1 dose					lab draw. Heparin (100 unit/mL) 3 to 5 mL final flush						
☐ Other pre-meds:	CVAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw										
☐ Refill x one year		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						
□ CMP					authorization unless the insurance dictates otherwise.						
□ CBC □ H & P OR progress note(s) □ Medication List- Please list past and present DMARDS/b								MARDS/hiolog	ics helow		
						with dates of discontinue, if applicable					
☐ Infliximab Trough Levels					☐ Hepatitis B Surface Antigen						
□ Other					☐ Hepatitis B Core Antibody Total (not Core IgM) ☐ QuantiFERON-TB Gold						
a Qualitii ENON-15 GOID											
Provider Information											
Provider NDI.					Provider Phone:						
Provider NPI:					P	rovide	r 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 or 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: __