

Remicade (Infliximab) Patient Referral and Prescription Sheet

Patient Information										
Patient Name:						Date:	Date:			
DOB:						Height:	Height:		□ inches □ cm	
Allergies:						Weight:	Weight:			
Primary Diagnosis										
Diagnosis ICD-10					Diagnosis IC				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				K51.00	
□ Plaque Psoriasis L40.0					Psoriatic PsoriasisL40.52				L40.52	
□ Rheumatoid arthritis, unspecified M06.9					Ankylosing Spondylitis M4				M45.9	
Ulcerative Colitis, unspecified without complications K51.90					Other					
Medication Order										
Carteria Remicade	Renflexis	Avsola	🛛 Inflixim	nab	Inflectra	Zymfentra	🛛 Refi	ills 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 Nursing Orders Skilled nursing visit for clinical assessment, administration of medication. Initiate plan of treatment for							from date of signature unless indicated below Refills rg 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:					 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					
CMP CBC LFTs CRP Infliximab Trough Levels					 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:										

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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