KabaFusion
Patient-Focused Infusion Therapy

5955 Core Road, Suite 512 | North Charleston, SC 29406
P: 888.211.7439 | eFax: 854.999.4977

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 ❑ CBC ❑ LFTs ❑ CRP ❑ Infliximab Trough Levels ❑ Other _____	❑ 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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