

Date Required: _____ Ship To: Patient MD Office Other: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____	ID: _____	Group: _____
Secondary Insurance: _____	ID: _____	Group: _____
Prescription Card: _____	ID: _____	BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:**PATIENT DIAGNOSIS/CLINICAL INFORMATION**

<input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> K50.00 Crohn's Disease <input type="checkbox"/> L40.0 Moderate to Severe Plaque Psoriasis <input type="checkbox"/> L40.50 Psoriatic Arthritis <input type="checkbox"/> L40.59 Psoriasis with Arthropathy <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> K51.90 Ulcerative Colitis <input type="checkbox"/> Other: _____	TB/PPD test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Date Read: _____ CHF History? <input type="checkbox"/> No <input type="checkbox"/> Yes: NY Class _____ (I-IV) Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Height: _____ <input type="checkbox"/> cm <input type="checkbox"/> in %BSA: _____ Allergies: _____ <input type="checkbox"/> NKDA <input type="checkbox"/> Pharmacy to coordinate home health nursing visit as necessary: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Home health nursing coordination not necessary. Reason: <input type="checkbox"/> MD office to administer to patient <input type="checkbox"/> Home health nursing already coordinated
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MEDICATION ORDERS► Orders are initiated unless crossed out by provider. Check to initiate order.**Administration Frequency**

-
- One dose
-
-
- 3 doses (at 0, 2 and 6 weeks)
-
-
- Maintenance every ____ weeks
-
-
- 3 doses (at 0, 2 and 6 weeks) followed by infusions every ____ weeks thereafter

Dose

-
- RPH will round up to nearest multiple of 100
-
-
- Give exact dose (do NOT round)
-
-
- 5mg/kg over at least 2 hours**
-
-
- 10 mg/kg over at least 2 hours**
-
-
- Other: ____ mg/kg over at least 2 hours**

**Dose based on actual body weight

Administration Instructions

- Dilute in 250mg 0.9% NaCl to a final concentration of 0.4 to 4 mg/ml.
- Do not infuse other medications through the same line.
- Infuse over at least 2 hours. Begin at 10 ml/hr and increase rate according to infusion rate chart.

To Manage Infusion Reactions:

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- Methylprednisolone 125mg IV x 1 dose PRN severe urticaria, pruritis or SOB (Notify Physician).
-
- Infusion Reaction Management per InfuCare Rx protocol:
- Acetaminophen 650mg PO Qh PRN aches or temperature increases $\geq 2^{\circ}\text{F}$.
 - Diphenhydramine 50mg IV x 1 dose PRN urticaria, pruritis or SOB.
 - Epinephrine 0.3mg IM PRN anaphylaxis may repeat in 15 minutes and call 911.

Nursing Orders:

- If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours as needed.
 - Weight should be taken before each dose.
 - Monitor vital signs (pulse and blood pressure) before therapy and every 15 to 30 minutes until 30 minutes after therapy.
 - If an infusion reaction occurs, decrease rate and monitor vital signs until symptoms subside. If reaction persists or worsens, stop infusion and notify Physician.
 - Observe patient for 30 minutes after completion of therapy.
-
- Other: _____

Labs:

- | | | |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> CBC with Diff: | <input type="checkbox"/> at each dose | <input type="checkbox"/> every: _____ |
| <input type="checkbox"/> Hepatic function panel: | <input type="checkbox"/> at each dose | <input type="checkbox"/> every: _____ |
| <input type="checkbox"/> CRP: | <input type="checkbox"/> at each dose | <input type="checkbox"/> every: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> at each dose | <input type="checkbox"/> every: _____ |

Pre-Medications & Other Medications

- Infusion supplies as per protocol Diphenhydramine _____ mg PO IV
- Anaphylaxis Kit as per protocol 250ml 0.9% NaCl for hydration
- Acetaminophen _____ mg PO prior to infusion Other: _____

Flush Protocol

- NaCl 0.9% 10ml
- Before and after infusion

Infusion Rate	Time
10 ml/hr	For 15 minutes
20 ml/hr	For 15 minutes
40 ml/hr	For 15 minutes
80 ml/hr	For 15 minutes
150 ml/hr	For 30 minutes
250 ml/hr	Until end of therapy

*By signing this form and using our services, you are authorizing InfuCare Rx to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.***Prescriber Signature: _____ Date: _____ UPIN: _____**