InfuCare Rx

Remicade Referral Form

of Pages Faxed: _____
Fax Referral To: 877-277-9155
Phone: 877-828-3940

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

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ ☐ Male ☐ Female
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
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

☐ M45.9 Ankylosing Spondylitis
☐ K50.00 Crohn's Disease
☐ L40.0 Moderate to Severe Plaque Psoriasis
☐ L40.50 Psoriatic Arthritis
☐ L40.59 Psoriasis with Arthropathy
☐ M06.9 Rheumatoid Arthritis
☐ K51.90 Ulcerative Colitis
☐ Other: _____

TB/PPD test: ☐ Positive ☐ Negative ☐ Date Read: _____
CHF History? ☐ No ☐ Yes: NY Class _____ (I-IV)
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary. Reason:
☐ MD office to administer to patient
☐ Home health nursing already coordinated

MEDICATION ORDERS

► **Orders are intiated unless crossed out by provider.** ☐ **Check to initate 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.

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

To Manage Infusion Reactions:
☐ Methylprednisolone 125mg IV x 1 dose PRN servere urticaria, pruritis or SOB (Notify Physician).
► Infusion Reaction Management per InfuCare Rx protocol:
- Acetaminiphen 650mg PO Qh PRN aches or temperature increases ≥2°F.
- Diphenhydramine 50mg IV x 1 dose PRN urticaria, prurtis 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 peripherial 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:
☐ CBC with Diff: ☐ at each dose ☐ every: _____
☐ Hepatic function panel: ☐ at each dose ☐ every: _____
☐ CRP: ☐ at each dose ☐ every: _____
☐ Other: _____ ☐ every: _____

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

Flush Protocol
► NaCl 0.9% 10ml
► Before and after infusion

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:** _____