# InfuCare Rx

# Remicade™ Enrollment Form

Fax Referral To: 877-277-9155
Phone: 877-828-3940

✂ Please cut along the dotted lines before submitting to a pharmacy.

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

## PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
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**
☐ Pharmacist will round to the nearest 100
☐ Give exact dose (do NOT round)
☐ 5mg per kg over at least 2 hours**
☐ 10 mg per kg over at least 2 hours**
☐ Other: ____ mg per 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 per mL.
► Do not infuse other medications through the same line.
► Infuse over at least 2 hours. Begin at 10 mL per hr and increase rate according to infusion rate chart.

| Infusion Rate | Time |
|---|---|
| 10 mL per hr | For 15 minutes |
| 20 mL per hr | For 15 minutes |
| 40 mL per hr | For 15 minutes |
| 80 mL per hr | For 15 minutes |
| 150 mL per hr | For 30 minutes |
| 250 mL per 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: _____

**Premedications & 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 this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.*

**Prescriber Signature:** _____ **Date:** _____