REMICADE®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

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

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
City, State, Zip: _____
Plan #: _____
Group #: _____
Phone: _____

RX Card (PBM): _____
BIN: _____ PCN: _____
City, State, Zip: _____
Group #: _____
Phone: _____

CLINICAL INFORMATION

☐ K51.90 Moderate to Severe Ulcerative Colitis
☐ K50.90 Moderate to Severe Crohn's Disease
☐ M06.9 Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ L40.52 Psoriatic Arthritis
☐ L40.0 Plaque Psoriasis
☐ Other: _____

*If PPD test results are not within 12 months, please perform PPD.
Tuberculosis Screening: ☐ PPD Test Date: _____-_____-_____
Results: ☐ Negative
☐ Positive → ☐ Chest X-Ray Performed Date: ____-_____-_____
X-Ray Results: ☐ Negative
☐ Positive → TB treatment Initiated

Labs:
☐ CBC q: _____ ☐ CMP q: _____ ☐ CRP q: _____ ☐ ESR q:_____ ☐ LFTs q: _____ ☐ X-Ray: _____ ☐ Other: _____
**Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____

REMICADE®

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Infusion: _____

Medication	Directions	Quantity/Refills
Remicade® (infliximab)	**Loading dose:** ☐ 5mg/kg _____ mg IV at week: 0, 2, 6 ☐ 3mg/kg _____ mg IV at week: 0, 2, 6 ☐ Other: _____ ☐ **Maintenance dose:** (_____ mg/kg) _____ mg IV every _____ weeks	**Loading dose:** 3 doses. No refills. **Maintenance dose:** 8-week supply. Refill x 1 year unless noted otherwise. ☐ _____ week supply Refill x 1 year unless noted otherwise. ☐ Other: _____

Pre- Medication	Route	Dose
☐ Acetaminophen	☐ By mouth	☐ 500mg ☐ 650mg ☐ 1000mg
☐ Methylprednisolone (Solu-Medrol)	☐ IV	☐ 60mg ☐ 100 mg ☐ _____mg
☐ Diphenhydramine (Benadryl)	☐ IV ☐ By mouth	☐ 25mg ☐ 50mg
Other: _____	_____	_____

ANAPHYLACTIC REACTION (AR):

☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary
☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary
☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary
☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access

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☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr

☐ Other: _____

IV ACCESS

☐ Start PIV if no IV access available ☐ Maintain current central line access

MONITORING PARAMETERS

☐ Obtain vital signs and temperature every 15 mins for the 1st hour, then every 30 mins for the remainder of the infusion

☐ Observe patient for 30 mins following the infusion

☐ Instruct patient to report symptoms of chills, fever, headache, sore throat, pain, etc.

☐ Other: _____

CATHETER CARE

☐ Sodium Chloride 0.9% _____ mL IV before and after each IV access and PRN per protocol

☐ Sodium Chloride 0.9% _____ mL as above AND Heparin 100 Units /mL _____ mL IV flush after second saline flush and PRN

☐ Dressing changes weekly and PRN ☐ Antimicrobial dressing PRN

☐ May obtain blood from IV access for labs ☐ May use Cathflo 2 mg/2 mL sterile water IVP 2 mL per lumen; May repeat after 2 hours x 1

STANDARD ORDER FOR SIDE EFFECTS

☐ Promethazine 25 mg – 1-2 tabs po q 4-6 hrs PRN nausea / vomiting

☐ Acetaminophen 325 mg - 2 tabs po q 4-6 hrs PRN HA, myalgia, fever

☐ Promethazine 25 mg IV/IM x 1 dose PRN nausea / vomiting

☐ Diphenhydramine 25 mg - 1 to 2 caps po PRN

☐ Diphenhydramine 25 mg -or- 50 mg IV x 1 dose PRN

☐ Other: _____

SIGNATURE

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.