

Remicade Biosimilar Referral Form



PHONE: 1-800-277-7302 FAX: 1-866-374-6663

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ Cell Alternate Phone #: _____ Cell

Height: _____ in/ft **Weight:** _____ lbs/kg Date weight recorded: _____ **Last 4 of SSN:** _____

Allergies: _____ NKDA

Diagnosis Information: Ulcerative Colitis K51.90 Crohn's Disease K50.00 Plaques Psoriasis L40. _____

Psoriatic Arthritis L40.53 Rheumatoid Arthritis M05.79 Ankylosing Spondylitis M45.0

Other Diagnosis/ICD10Code _____

Date Infusion to Begin: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	List of Failed Therapies: _____

Assessment Questions: *Please Provide Appropriate Documentation*

Diabetes? Yes No HTN? Yes No Cardiac History? Yes No Difficulty Breathing? Yes No

Requires Oxygen? Yes No Confusion /Disorientation? Yes No Neuro History? Yes No

Date of Negative TB test: _____ **Date of negative Hep B Screen:** _____

Inflectra®:(infliximab-Dyyb)Q5103 **Avsola®(infliximab-axxq)Q5121**

Renflexis®(infliximab-abda)Q5104 **Other Biosimilar** _____ **Insurance to Dictate**

5 mg/kg or _____ mg/kg IV at 0, 2, 6 weeks followed by a dose every 8 wees for _____ months. Titrate per IVCO policy

Maintenance dose: 5mg/kg or _____ mg/kg IV every _____ weeks for _____ months. Titrate per IVCO policy

FOR RA: **Is patient also taking methotrexate?** Yes No If not, please document reason: _____

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion. *Pt. to receive 50ml NS pre- and post- infusion.*

Benadryl 25 MG PO x1 Benadryl 50 mg PO x1

Acetaminophen 325 mg PO x1 Acetaminophen 650 mg PO x1

Other Pre-medication: _____

<p>Access: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV</p> <p>Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency</p> <p>PIV – NS 5mL: Qty 10</p> <p>PORT – NS 10mL: Qty 10, Heparin 5mL 100units/mL x 1 per infusion.</p> <p>PICC – NS 10mL: Qty 10, Heparin 5mL 10units/mL x 1 per infusion</p>	<p>Supplies: (please strike through if not required)</p> <p>Administration Supplies (A4222) – 1 per infusion</p> <p>Catheter Care Supplies (A4221) – 1 per week</p> <p>Infusion Pump (E0781)</p> <p>Nursing services to administer</p> <p>Administration through an in-line 1.2-micron or less, sterile, nonpyrogenic, low-protein binding filter is required</p>
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For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures

Physician/PA signature: _____

NPI # _____ Phone Number _____

Office Address: _____ City: _____ St GA Zip: _____

Printed Name: _____ Contact Name: _____

Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H & P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.

05/21 TSP