

# 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?**  YES  NO  
Previous Infusion Reaction:  YES  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 HBcAb, HBsAg, HBsAb:** \_\_\_\_\_

**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 weeks 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><b>Access:</b> <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC <b>Route:</b> <input type="checkbox"/> IV Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency PIV – NS 5mL: Qty 3 PORT – NS 10mL: Qty 3, Heparin 5mL 100units/mL x 1 per infusion. PICC – NS 10mL: Qty 3, Heparin 5mL 10units/mL x 1 per infusion</p>	<p><b>Supplies:</b> (please strike through if not required) Administration Supplies (A4222) – 1 per infusion Catheter Care Supplies (A4221) – 1 per week Infusion Pump (E0781) Nursing services to administer <b>Administration through an in-line 1.2-micron or less, sterile, nonpyrogenic, low-protein binding filter is required</b></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 \_\_\_\_\_ 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.**