# Remicade® Referral Form

IVCareOptions

**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: _____

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _____

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: _____

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: _____

**Remicade® (Infliximab): J1745**
☐ 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
☐ 3 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 of a 50ml bag of 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: _____

**Access**: ☐ **PIV** ☐ **PORT** ☐ **PICC** **Route:** ☐ **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

**Supplies:** (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

**Administration through an in-line 1.2-micron or less, sterile, nonpyrogenic, low-protein binding filter is required**

***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.**