Biologics referral form

Infusion Pharmacy Phone: Fax:

✂ Please detach before submitting to a pharmacy - tear here.

Care specialist Name: Phone:

Patient information ☐ see attached

Patient name: Gender: ○ M ○ F DOB: Last 4 of SSN:
Address: City: State: ZIP:
Phone: Cell:
Emergency contact: Phone: Relationship:

Insurance: ☐ Front and back of insurance card to follow
Primary Insurance: Phone: Policy #: Group:
Secondary Insurance: Phone: Policy #: Group:

Primary diagnosis: ☐ ICD10 Code: Diagnosis:

Medical assessment: Height: Weight: ○ lbs ○ kg

Current medications? ○ Yes ○ No If yes, list or attach:
Allergies:

☐ TB test: most recent date: ☐ see attached for results and details ☐ No TB test in past year

Tried and failed therapies: Include supportive clinical documents

☐ Azathioprine ☐ Corticosteroids ☐ Enbrel ☐ Humira ☐ Methotrexate ☐ NSAIDS
☐ 5-Aminosalicyclic Acid Agents ☐ 6-mercaptopurine
☐ Other:

Prescription and orders Medication infused per the drug PI recommended rate and via rate controlled device per therapy

Medication	Dose and directions
Entyvio, x1 year Adult Ulcerative Colitis and Crohn's Disease	First Dose: ○ YES ○ NO If NO, indicate when next dose is needed: Induction Dose: Week 2, Date Due: Week 6, Date Due: Maintenance Dose: Date Due: ☐ Induction Dose: Infuse 300mg IV at weeks 0, 2 and 6 ☐ Maintenance Dose: Infuse 300mg IV every 8 weeks
Stelara, x1 year Adult Ulcerative Colitis and Crohn's Disease	First Dose: ○ YES ○ NO If NO, indicate when next SC dose is needed: Date Due: ☐ Intravenous Induction Dose: ○ Patients weighing ≤ 55 kg, Infuse 260 mg (2 x130mg/26ml vials) IV at week 0 ○ Patients weighing > 55 kg to 85 kg: Infuse 390 mg (3 x 130mg/26ml vials) IV at week 0 ○ Patients weighing > 85 kg: Infuse 520 mg (4 x 130mg/26ml vials) IV at week 0 ☐ SC Maintenance Dose: Inject 90mg SC every 8 weeks
Infliximab (Remicade; Inflectra; Renflexis; Avsola), x1 year Adult and Pediatric Crohn's Disease and Ulcerative Colitis; Adult Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Plaque Psoriasis.	☐ No infliximab product preference ☐ Preferred product: First Dose: ○ YES ○ NO Indicate when next dose is needed if still in induction phase: Induction Dose: Week 2, Date Due: Week 6, Date Due: Maintenance Dose: Date Due: ☐ Induction Dose: Infuse 5mg/kg or mg/kg IV at weeks 0, 2 and 6 ☐ Maintenance Dose: Infuse mg/kg IV every 8 weeks OR mg/kg IV every weeks Infusion time: Infuse over hours if different than PI recommendation

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Medication	Dose and directions
Pre-Medications, x1 year	Administer 30 minutes prior to infusion ☐ Acetaminophen ○ 325mg PO ○ 650mg PO ○ mg PO ☐ DiphenhydrAMINE ○ 25mg PO ○ 50mg PO ○ mg PO ☐ Other
Lab Orders, x1 year	☐ Albumin ☐ ALT ☐ AST ☐ CBC ☐ Creatinine ☐ CMP ☐ CRP ☐ ESR ☐ LFT ☐ Platelets ☐ Other Frequency of labs:
Nursing Orders, x1 year	Nursing to administer prescribed medication and establish and/or maintain IV access device. IV access to be flushed by nurse: • Sodium Chloride 0.9%: 5mls pre-infusion and 5mls post infusion • If Entyvio: Sodium Chloride 0.9% 5mls pre infusion and 30mls post infusion • If Port access: Sodium Chloride 0.9%, 10mls pre-infusion and 10mls post-infusion followed by Heparin 100 units/ml, 5mls as final lock for patency
Pharmacy Orders, x1 year	Pharmacy to dispense flushes, needles, syringes and HME/DME quantity sufficient to complete therapy as prescribed.

☑ **Anaphylaxis Kit Order** Infusion Reaction Management x1 year

Mild	• Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated. ☐ DiphenhydrAMINE PO ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 25mg capsules x 4
Moderate	• Stop Infusion, resume at 50% rate when symptoms resolve ☐ DiphenhydrAMINE IV ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 50mg vial x 1
Severe (Anaphylaxis) ***Call 911*** **Notify prescribing physician**	• Stop infusion and remove tubing from access device to prevent further administration • Initiate 0.9% NaCl 500ml/hr IV OR ml/hr • **Administer EPINEPHrine 1mg/ml by weight (Wt.) as an IM injection into the lateral thigh** Wt > 66lbs (30kg) 0.3mg/0.3ml — Wt 33 to 66 lbs (15 to 30kg) 0.15mg/0.15ml — Wt < 33lbs (15kg) 0.01mg/kg • Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrive ☐ Dispense 0.9% NaCl 500ml x1 ☐ Dispense EPINEPHrine x 2 ☐ 1mg vial ☐ Pen 0.3mg ☐ Pen JR 0.15mg ☐ Other medication:

Physician information

Name: Practice:

Address: City: State: ZIP:

Phone: Fax: NPI: Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible signature Dispense as written signature Date

Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and labs ☐ TB results

Please include ALL pages when faxing