TNF/IRA REFERRAL FORM - IV Solutions RX

PATIENT:_____ SEX: ◯ MALE ◯ FEMALE WEIGHT:_____◯ LBS ◯ KGS HEIGHT:_____◯ IN ◯ CM

ADDRESS:_____ APT/SUITE:_____ CITY:_____ STATE:_____ ZIP:_____

PHONE:_____◯ HOME ◯ CELL ◯ WORK _____ ◯ HOME ◯ CELL ◯ WORK DOB: _____

**MAY WE LEAVE MESSAGES ON THE PHONE? ◯ YES ◯ NO MAY WE TEXT YOU? ◯ YES ◯ NO SSN:_____

EMERGENCY CONTACT:_____ PHONE:_____

INSURANCE INFORMATION: FAX FRONT AND BACK OF ALL INSURANCE CARDS

PRIMARY INSURANCE:_____ ID:_____ GROUP:_____INSURED PARTY:_____

SECONDARY INSURANCE:_____ ID:_____ GROUP:_____INSURED PARTY:_____

CLINICAL INFORMATION: CLINICAL NOTES, LABS, TEST RESULTS, MEDICATION HISTORY, ALLERGIES

ICD-10:_____ DIAGNOSIS: _____QuantiFERON: ◯ Y ◯ N DATE:_____ HEPATITIS B: ◯ Y ◯ N DATE:_____

ACCESS DEVICE: ◯ PERIPHERAL ◯ IMPLANTED PORT ◯ PICC ◯ OTHER:_____

PREVIOUS TNF Medications: ◯ YES ◯ NO IF YES, WHAT WERE THEY:_____ DATE:_____

ALLERGIES: ◯ NKDA ◯ OTHER:_____

PRESCRIPTION: Administration by manufacturer guidelines and per state law, prescriptions will be dispensed as generic unless otherwise noted.

◯ Remicade ◯ Inflectra ◯ Renflexis ◯ Entyvio ◯ Other:_____

DOSE: _____MG/KG or _____MG (TOTAL)

Remicade (Infliximab) will be rounded to the nearest 100mg/vial or nearest 10mg for doses <101mg, unless the box is checked ◯

◯ INDUCTION: Infuse IV on week 0, 2 weeks, 6 weeks and then every 8 weeks for 1 year, unless specified

◯ MAINTENANCE ONLY: Infuse IV every _____weeks for 1 year

◯ Simponi Aria DOSE: _____ MG/KG or _____ MG (TOTAL)

◯ INDUCTION: Infuse IV on week 0, week 4, then every 8 weeks for 1 year, unless specified

◯ MAINTENANCE: Infuse IV every _____weeks for 1 year

◯ PRE-MEDICATIONS/PROTOCOLS ADULT AND PEDIATRICS:

◯ DIPHENHYDRAMINE_____MG 30 MINUTES BEFORE INFUSION. ◯ MAY REPEAT PRN UP TO EVERY _____ HOURS

◯ PO capsule ◯ PO Liquid 12.5mg/5mL ◯ Chewable ◯ IV Push

◯ ACETAMINOPHEN_____MG PO 30 MINUTES BEFORE INFUSION. ◯ MAY REPEAT PRN UP TO EVERY _____ HOURS

◯ PO tablet ◯ PO liquid 160mg/5mL ◯ Chewable tablet

◯ HYDRATION: INFUSE _____mL OF _____ SOLUTION ◯ PRIOR ◯ AFTER INFUSION

◯ SOLUMEDROL®____MG ◯ IVP ◯ INFUSE IN 0.9% SODIUM CHLORIDE 50-250ML OVER 30 MINUTES ◯ OTHER:_____

FLUSHING PROTOCOL:

◯ SODIUM CHLORIDE 0.9% 5-10mL PRE AND POST MEDICATIONS ◯ HEPARIN _____Units/mL _____mL as needed

ANAPHYLAXIS ORDERS AND MEDICATIONS:

1. STOP THE INFUSION, then call 911, the PRESCRIBING PHYSICIAN and the PHARMACY (844-650-5802)
2. ADMINISTER MEDICATIONS BELOW AS PER PROTOCOL: DIPHENHYDRAMINE 50MG/mL (1 vial)
   - ◯ ADMINISTER 50MG/mL (weight > 30kg) by slow IV push or IM
   - ◯ ADMINISTER 25MG/0.5mL (weight 15 - 30kg) by slow IV push or IM
   - ◯ ADMINISTER 12.5MG/0.25 mL (weight 7.5 - 15kg) by slow IV push or IM
3. EPINEPHRINE (VIAL OR AUTOINJECTOR): ADMINISTER IM FOR SEVERE ANAPHYLACTIC REACTION, MAY REPEAT IN 5-15 MINUTES IM x 1.
   - ◯ 0.3MG (weight > 30kg) ◯ 0.15MG for PEDIATRICS (weight 15-30kg) ◯ 0.1 MG for PEDIATRICS (weight 7.5-15kg)
4. ◯ SODIUM CHLORIDE 0.9% 500mL IV use as directed

NURSING/LABS/SUPPLIES:

NURSING: Nursing visits with each infusion to establish venous access, administer and maintain medication, assess and monitor patient, provide education and complete lab draws.

Labs: Please select labs to be drawn prior to and infusion by the nurse. ◯ CBC ◯ CMP ◯ Sed Rate ◯ LFT ◯ Hepatitis B ◯ Other: _____

Frequency of labs: ◯ Annually or ◯ Every _____ month(s).

QuantiFERON test shall be ordered by the prescriber and drawn at an outside facility at a frequency deemed appropriate

Supplies: ◯ Dispense medication, pump, and supplies necessary for infusion.

PRESCRIBER OF RECORD

PRESCRIBER:_____ NPI:_____ TAX ID:_____

ADDRESS:_____ CITY:_____STATE:_____ ZIP CODE:_____

CONTACT:_____ PHONE:_____ FAX:_____

PRESCRIBER'S SIGNATURE:_____ DATE:_____

I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX. CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to info@ivsolutionsrx.com and destroy all copies of the original message.

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