BIOLOGICAL (IV) PRESCRIPTION AND REFERRAL FORM

Patient Information

Please submit front and back copies of all medical & prescription insurance cards.

Patient Name: _____ ☐ Male ☐ Female Primary Language: _____
Address: _____ Apt/Suite: _____ City: _____ ST: _____ ZIP: _____
DOB: _____ SSN: _____ Phone: _____
Alt Phone: _____ **May we leave a message on either line? ☐ YES ☐ NO May we text you? ☐ YES ☐ NO
Emergency Contact: _____ Phone: _____ Relation: _____
Primary Insurance: _____ ID: _____ Group: _____ Cardholder: _____
Secondary Insurance: _____ ID: _____ Group: _____ Cardholder: _____

Clinical Information

Please submit clinic notes, medical history, labs, test results, and medication list.

Allergies: ☐ NKDA ☐ Other: _____ Access Type: ☐ Peripheral ☐ Implanted Port ☐ Other: _____
ICD-10: _____ Diagnosis: _____
☐ Date of Last Negative TB Test: _____ **or** ☐ Completion Date of TB treatment: _____
☐ Date of last Hepatitis B screen: _____ **or** ☐ Completion Date of HBV vaccination: _____
Previous Therapy? ☐ No ☐ Yes, and Product Name: _____ Date of last treat: _____
Ht: _____ ☐ IN ☐ CM Wt: _____ ☐ LB ☐ KG Do you want dose adjusted for weight > 100 kg? ☐ No ☐ Yes

Prescription Order

Administered per manufacturer guidelines. Per state law, prescriptions will be dispensed as generic unless otherwise noted.

☐ Remicade® ☐ Inflectra® ☐ Renflexis® ☐ Entyvio® ☐ Fixed-dose: _____ mg, or ☐ Weight-based: _____ mg/kg
Important: Infliximab will be rounded to the nearest 100mg/vial (or nearest 10mg for doses < 100mg) UNLESS the following box is checked ☐
☐ INDUCTION + MAINTENANCE: Administer at weeks 0, 2, and 6, then every 8 weeks thereafter.
☐ MAINTENANCE ONLY: Administer every _____ weeks. * * May adjust infusion schedule +/- 3 days if nursing need arises * *
☐ Entyvio® only: Upon completion of infusion, flush IV line with 30-50 mL of Sodium chloride 0.9%.

☐ Simponi Aria® ☐ Fixed-dose: _____ mg, or ☐ Weight-based: _____ mg/kg
Important: Simponi Aria® will be rounded to the nearest 50mg/vial (or nearest 10mg for doses < 100mg) UNLESS the following box is checked ☐
☐ INDUCTION + MAINTENANCE: Administer at weeks 0 and 4, then every 8 weeks thereafter.
☐ MAINTENANCE ONLY: Administer every _____ weeks. * * May adjust infusion schedule +/- 7 days if nursing need arises * *

ANCILLARY MEDICATIONS: ☐ With every infusion ☐ PRN upon patient request.
☐ Acetaminophen _____ mg PO. ☐ Give 30 to 60 minutes before infusion. ☐ May repeat every _____ hours PRN.
☐ Diphenhydramine _____ mg ☐ PO ☐ IV. ☐ Give 30 to 60 minutes before infusion. ☐ May repeat every _____ hours PRN.
☐ SoluMedrol® ☐ SoluCortef® Give _____ mg prior to infusion via ☐ IV push ☐ diluted in _____ mL of NS over 30 minutes.
☐ Emla® cream (30 grams). Apply topically 30 to 60 minutes prior to access.
☐ Other: _____

FLUSHING PROTOCOL: ☑ Sodium chloride 0.9%, 5-10 mL before/after medication, and/or PRN to maintain patency.
☐ Heparin _____ units/mL, _____ mL as final flush and/or PRN to maintain patency

ANAPHYLAXIS PROTOCOL: 1) Stop infusion. Call 911. 2) Administer medications below per protocol.

Epinephrine (vial or autoinjector): Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes x 1.	Diphenhydramine (50mg/mL vial) via IM or slow IV push
☐ 0.3 mg (Wt > 30 kg) ☐ 0.15 mg (Wt 15-30 kg) ☐ 0.1 mg (Wt 7.5-15 kg)	☐ 50 mg (Wt > 30 kg) ☐ 25 mg (Wt 15-30 kg) ☐ 12.5mg (Wt 7.5-15kg) ☑ Sodium Chloride 0.9%, 500 mL IV as directed

NURSING / LABS / SUPPLIES:
☑ Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.
☑ Diluent, infusion supplies, and infusion pump PRN for the reconstitution, administration, and disposal of medication.
☑ [Dx code: Z79.899] Labs as follows, to be drawn annually by RN prior to infusion unless frequency is specified: every _____ ☐ month(s)
☑ CMP ☑ CBC w/ diff ☑ Acute Hepatitis Panel ☐ Other: _____.
☑ TB test shall be ordered at a frequency deemed appropriate and performed by an outside lab facility.

Dispense (all above): ☐ up to 1-month supply + refills x 1 year ☐ up to 2-month supply + refills x 1 year ☐ Other: _____

Prescriber Information

Prescriber: _____ NPI: _____
Address: _____ Apt/Suite: _____ City: _____ ST: _____ ZIP: _____
Office 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 fills 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 privileged and 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 you are 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 replying by email at info@ivsolutionsrx.com and then destroying all copies of the original message.