Remicade/Remicade Biosimilars
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

1 PATIENT'S INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
Address: _____ **City/State/Zip:** _____
Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____
Primary RX Insurance:_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

3 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10) and Patient Clinical Information:
Drug Allergies:_____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg
Diagnosis (ICD-10)**:** _____ Description: _____

Pre-Clinical Information:
TB Test Date:_____ ☐ Positive **(+)** ☐ Negative **(-)** **Hepatitis-B Test Date:**_____ ☐ Positive **(+)** ☐ Non-Reactive **(-)**

Labs: Please fax copy of the following labs dated within 1 year of the patients referral request:
☐ **CMP** ☐ **CBCw/ diff** ☐ **Hepatitis (B)** ☐ **QuantiFERON** (QFT) **/ TB/ T-Spot**

4 PRESCRIPTION INFORMATION

ACCESS: ☐ IV ☐ PORT

RX INFORMATION: Our pharmacist will identify clinically appropriate brand *(Unless product is specifically specified at the time of referral)* and infusion rate per FDA guidelines. Clinically appropriate substitutions may be allowed based on availability or payor requirements. Dose(s) will be rounded to the nearest vial size. Official orders will be outlined with "May Infuse" +/- 3 days if scheduling needs arises, with insurance payor approval".

PRODUCTS: ☐ **Avsola** ☐ **Inflectra** ☐ **Infliximab** ☐ **Remicade** ☐ **Renflexis**

☐ **LOADING DOSE:** _____ mg/Kg **or** _____ mg (TOTAL) Infuse on weeks_____ and then every _____ weeks for 1 Year, unless specified.

☐ **MAINTENANCE DOSE:** _____ mg/Kg **or** _____ mg (TOTAL) Infuse IV every _____ weeks for 1 Year, Unless Specified.

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ SoluMedrol® **(IV)**	Give _____ mg prior to infusion via ☐ IV push ☐ diluted in _____ mL of NS over 30 min.	Quantity: **Q.S**	Refills: **PRN**
☐ Diphenhydramine: ☐ PO ☐ IV	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Acetaminophen **(PO)**	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Hydration: ☐ 0.9% NaCL ☐ LR	Infuse _____ mL of _____ solution ☐ before ☐ after infusion.	Quantity: **Q.S**	Refills: **PRN**
☐ Emla® cream	Apply topically 30 to 60 minutes prior to access.	Quantity: **Q.S**	Refills: **PRN**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(vial or autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x1) Vial** or **(x2) Pen(s)**	Refills: **PRN**
☒ DIPHENHYDRAMINE **(50mg/mL)**	Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)***	Quantity: **(x1) Vial(s)**	Refills: **PRN**
☒ SODIUM CHLORIDE 0.9% **(IV)**	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: **500 mL**	Refills: **PRN**

NURSING/ LABS/ INFUSION SUPPLIES:

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

☒ **INFUSION SUPPLIES:** Infusion supplies and infusion pump PRN for the administration and disposal of medication.

FLUSHING PROTOCOL: ☒ Sodium chloride 0.9%, up to 10 mL before/after medication, and/or PRN to maintain patency.
☐ Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency

☒ **LABS:** *[Dx code: Z79.899]*; Labs to be drawn by RN prior to infusion every _____ ☐ Week ☐ Month(s), as followed:
☐ **CMP** ☐ **CBC w/ diff** ☐ **Sed Rate** ☐ **LFT** ☐ **Hepatitis-B** ☐ **Other:** _____

5 PRESCRIBER INFORMATION

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:**_____
Address:_____ **City/ State/ Zip:** _____
Phone:_____ **Fax:** _____ **Contact Person:**_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
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.

_____ **Physicians signature** _____ **Date**

THANK YOU FOR YOU TRUSTING US IN YOUR PATIENTS SPECIALTY CARE *#welcome to our family*