



REMICADE® (infliximab) & Biosimilar

Please Fax Completed Form To: 888-340-3699
 Please Send a Copy of The Patient's Insurance Cards (Front & Back)
 Please Send a Copy of The Patient's Up-to-Date Clinical Notes

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____
--	--

CLINICAL INFORMATION

<input type="checkbox"/> K51.90 Moderate to Severe Ulcerative Colitis <input type="checkbox"/> K50.90 Moderate to Severe Crohn's Disease <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> L40.52 Psoriatic Arthritis <input type="checkbox"/> L40.0 Plaque Psoriasis <input type="checkbox"/> Other: _____	*If PPD test results are not within 12 months, please perform PPD. Tuberculosis Screening: <input type="checkbox"/> PPD Test Date: ____-____-____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Chest X-Ray Performed Date: ____-____-____ X-Ray Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive TB treatment Initiated
--	--

Labs:
 CBC q: _____ CMP q: _____ CRP q: _____ ESR q: _____ LFTs q: _____ X-Ray: _____ Other: _____

REMICADE®

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Infusion: _____

Medication	Directions	Quantity/Refills
<input type="checkbox"/> Remicade® (infliximab) <input type="checkbox"/> Inflectra® (infliximab-dyyb) <input type="checkbox"/> Renflexis® (infliximab-abda) <input type="checkbox"/> Avsola® (infliximab-axxq)	Loading dose: <input type="checkbox"/> 5mg/kg _____ mg IV at week: 0, 2, 6 <input type="checkbox"/> 3mg/kg _____ mg IV at week: 0, 2, 6 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Maintenance dose: (_____ mg/kg) _____ mg IV every _____ weeks	Loading dose: 3 doses. No refills. Maintenance dose: 8-week supply. Refill x 1 year unless noted otherwise. <input type="checkbox"/> _____ week supply Refill x 1 year unless noted otherwise. <input type="checkbox"/> Other: _____

Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg <input type="checkbox"/> 25mg IV/PO	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 50mg IV/PO <input type="checkbox"/> 40mg 100mg	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 125mg _____	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion
<input type="checkbox"/> _____		

INFUSION REACTION ORDERS

Mild reaction protocol:

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.



REMICADE® (infliximab) & Biosimilar

Please Fax Completed Form To: 888-340-3699

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Please Send a Copy of The Patient's Up-to-Date Clinical Notes

Diphenhydramine 25mg IV, one time, for pruritus.

If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

- Acetaminophen 650mg PO, one time, for pyrexia or rigors
- Diphenhydramine 50mg IV, one time, for pruritus or urticaria
- Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

- Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)
- Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms
- Epinephrine 0.3mg/0.3mL IM into mid-antrolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline: <input checked="" type="checkbox"/> 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: <input checked="" type="checkbox"/> 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw
---	--

Locking Protocol (>66lbs/33kg)

PIV and Midline: <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	PICC: <input checked="" type="checkbox"/> Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	Implanted Port, Tunneled Catheter, and Non-tunneled Catheter: <input checked="" type="checkbox"/> Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush
---	--	---

****May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral

X _____

Prescriber Signature

Date: _____

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.