



Biologics referral form

Infusion pharmacy

Phone: _____

Fax: _____

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

PATIENT INFORMATION

Acute care specialist name:		Phone:	
Patient: <input type="checkbox"/> see attached Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Patient name:		DOB:	SSN:
Address:			City:
State:	ZIP:	Phone:	Cell:
Emergency contact:		Phone:	Relationship:
Insurance: <input type="checkbox"/> Front and back of insurance card to follow			
Primary Insurance:	Phone:	Policy #:	Group:
Secondary Insurance:	Phone:	Policy #:	Group:
Primary diagnosis: <input type="checkbox"/> ICD10 Code:		Diagnosis:	
Medical assessment: Height: _____ Weight: _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg			
Current medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list or attach:	
Allergies:			
<input type="checkbox"/> TB test: most recent date: _____ <input type="checkbox"/> see attached for results and details <input type="checkbox"/> No TB test in past year			
Tried & failed therapies: Include supportive clinical documents			
<input type="checkbox"/> Azathioprine <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Enbrel <input type="checkbox"/> Humira <input type="checkbox"/> Methotrexate <input type="checkbox"/> NSAIDS			
<input type="checkbox"/> 5-Aminosalicylic Acid Agents <input type="checkbox"/> 6-mercaptopurine			
<input type="checkbox"/> Other:			

PRESCRIPTION AND ORDERS Medication infused per PI recommended rate and via rate controlled device per therapy

Medication	Dose & Directions
Entyvio, x1 year	First Dose: <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, indicate when next dose is needed: Induction Dose: Week 2, Date Due: _____ Week 6, Date Due: _____ Maintenance Dose: Date Due: _____ <input type="checkbox"/> Induction Dose: Infuse 300mg IV at weeks 0, 2 and 6 <input type="checkbox"/> Maintenance Dose: Infuse 300mg IV every 8 weeks
Stelara, x1 year	First Dose: <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, indicate when next SC dose is needed: Date Due: _____ <input type="checkbox"/> Intravenous Induction Dose: <input type="checkbox"/> Patients weighing ≤ 55 kg, Infuse 260 mg (2 x 130mg/26mL vials) IV at week 0 <input type="checkbox"/> Patients weighing > 55 kg to 85 kg: Infuse 390 mg (3 x 130mg/26mL vials) IV at week 0 <input type="checkbox"/> Patients weighing > 85 kg: Infuse 520 mg (4 x 130mg/26mL vials) IV at week 0 <input type="checkbox"/> SC Maintenance Dose: Inject 90mg SC every 8 weeks
Infliximab (Remicade; Inflectra; Renflexis), x1 year	<input type="checkbox"/> Remicade <input type="checkbox"/> Inflectra <input type="checkbox"/> Renflexis First Dose: <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ <input type="checkbox"/> Induction Dose: Infuse 5mg/kg or _____ mg/kg IV at weeks 0, 2 and 6 <input type="checkbox"/> 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

This form is not a valid prescription in Arizona.

Page 1 of 2, continued on page 2



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Patient name: _____ DOB: _____

PRESCRIPTION AND ORDERS Medication infused per PI recommended rate and via rate controlled device per therapy

Medication	Dose & Directions						
Pre-Medications, x1 year	Administer 30 minutes prior to infusion <input type="checkbox"/> Acetaminophen <input type="checkbox"/> 325mg PO <input type="checkbox"/> 650mg PO <input type="checkbox"/> _____mg PO <input type="checkbox"/> DiphenhydrAMINE <input type="checkbox"/> 25mg PO <input type="checkbox"/> 50mg PO <input type="checkbox"/> _____mg PO <input type="checkbox"/> Other _____						
Lab Orders, x1 year	<input type="checkbox"/> Albumin <input type="checkbox"/> ALT <input type="checkbox"/> AST <input type="checkbox"/> CBC <input type="checkbox"/> Creatinine <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFT <input type="checkbox"/> Platelets <input type="checkbox"/> Other _____ <input type="checkbox"/> 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: <ul style="list-style-type: none"> • 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.						
<input checked="" type="checkbox"/> Anaphylaxis kit order Infusion Reaction Management x1 year							
Mild	<ul style="list-style-type: none"> • Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated. <input checked="" type="checkbox"/> DiphenhydrAMINE PO <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> _____mg Dispense diphenhydrAMINE 25mg capsules x 4						
Moderate	<ul style="list-style-type: none"> • Stop Infusion, resume at 50% rate when symptoms resolve <input checked="" type="checkbox"/> DiphenhydrAMINE IV <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> _____mg Dispense diphenhydrAMINE 50mg vial x 1						
Severe (Anaphylaxis) *Call 911* Notify prescribing physician	<ul style="list-style-type: none"> • 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 <table border="0" style="margin-left: 20px;"> <tr> <td style="text-align: center;">Wt > 66lbs (30kg)</td> <td style="text-align: center;">Wt 33 to 66 lbs (15 to 30kg)</td> <td style="text-align: center;">Wt < 33lbs (15kg)</td> </tr> <tr> <td style="text-align: center;">0.3mg/0.3mL</td> <td style="text-align: center;">0.15mg/0.15mL</td> <td style="text-align: center;">0.01mg/kg</td> </tr> </table> • Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrives <input checked="" type="checkbox"/> Dispense 0.9% NaCl 500mL x 1 <input checked="" type="checkbox"/> Dispense EPINEPHrine x 2: <input type="checkbox"/> 1mg vial <input type="checkbox"/> Pen 1mg <input type="checkbox"/> Pen JR 0.15mg <input type="checkbox"/> Other medication: _____	Wt > 66lbs (30kg)	Wt 33 to 66 lbs (15 to 30kg)	Wt < 33lbs (15kg)	0.3mg/0.3mL	0.15mg/0.15mL	0.01mg/kg
Wt > 66lbs (30kg)	Wt 33 to 66 lbs (15 to 30kg)	Wt < 33lbs (15kg)					
0.3mg/0.3mL	0.15mg/0.15mL	0.01mg/kg					

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.

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

Signature: _____ Date: _____