Biologics referral form

Phone: _____

Fax: _____

PATIENT INFORMATION

Acute care specialist name:			Phone:
Patient: ☐ see attached Gender: ☐ Male ☐ Female			
Patient name:		DOB:	SSN:
Address:			City:
State:	ZIP:	Phone:	Cell:
Emergency contact:		Phone:	Relationship:
Insurance: ☐ Front and back of insurance card to follow			
Primary Insurance:	Phone:	Policy #:	Group:
Secondary Insurance:	Phone:	Policy #:	Group:
Primary diagnosis: ☐ ICD10 Code:		Diagnosis:	
Medical assessment: Height:_____ Weight:_____ ☐ lbs ☐ kg			
Current medications? ☐ Yes ☐ No		If yes, list or attach:	
Allergies:			
☐ TB test: most recent date:_____ ☐ see attached for results and details ☐ No TB test in past year			
Tried & failed therapies: Include supportive clinical documents			
☐ Azathioprine ☐ Corticosteroids ☐ Enbrel ☐ Humira ☐ Methotrexate ☐ NSAIDS			
☐ 5-Aminosalicyclic Acid Agents ☐ 6-mercaptopurine			
☐ 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: ☐ Yes ☐ No If NO, indicate when next dose is needed: Induction Dose: Week 2, Date Due: _____ Week 6, Date Due: _____ Maintenance Dose: Date Due: _____ ☐ Induction Dose: Infuse 300mg IV at weeks 0, 2 and 6 ☐ Maintenance Dose: Infuse 300mg IV every 8 weeks
Stelara, x1 year	First Dose: ☐ Yes ☐ No If NO, indicate when next SC dose is needed: Date Due:_____ ☐ Intravenous Induction Dose: ☐ Patients weighing ≤ 55 kg, Infuse 260 mg (2 x130mg/26mL vials) IV at week 0 ☐ Patients weighing > 55 kg to 85 kg: Infuse 390 mg (3 x 130mg/26mL vials) IV at week 0 ☐ Patients weighing > 85 kg: Infuse 520 mg (4 x 130mg/26mL vials) IV at week 0 ☐ SC Maintenance Dose: Inject 90mg SC every 8 weeks
Infliximab (Remicade; Inflectra; Renflexis; Avsola), x1 year	☐ Remicade ☐ Inflectra ☐ Renflexis ☐ Avsola First Dose: ☐ Yes ☐ 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: _____ ☐ Induction Dose: Infuse 5mg/kg or _____mg/kg IV at weeks 0, 2 and 6 ☐ 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

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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 ☐ Acetaminophen ☐ 325mg PO ☐ 650mg PO ☐ _____mg PO ☐ DiphenhydrAMINE ☐ 25mg PO ☐ 50mg PO ☐ _____mg PO ☐ Other _____
Lab Orders, x1 year	☐ Albumin ☐ ALT ☐ AST ☐ CBC ☐ Creatinine ☐ CMP ☐ CRP ☐ ESR ☐ LFT ☐ Platelets ☐ Other_____ ☐ 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: • 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.
☒ **Anaphylaxis kit order** Infusion Reaction Management x1 year	
Mild	• Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated. ☒ DiphenhydrAMINE PO ☐ 25mg ☐ 50mg ☐ _____mg Dispense diphenhydrAMINE 25mg capsules x 4
Moderate	• Stop Infusion, resume at 50% rate when symptoms resolve ☒ DiphenhydrAMINE IV ☐ 25mg ☐ 50mg ☐ _____mg Dispense diphenhydrAMINE 50mg vial x 1
Severe (Anaphylaxis) *Call 911* Notify prescribing physician	• 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** Wt > 66lbs (30kg) 0.3mg/0.3mL — Wt 33 to 66 lbs (15 to 30kg) 0.15mg/0.15mL — Wt < 33lbs (15kg) 0.01mg/kg • Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrives ☒ Dispense 0.9% NaCl 500mL x 1 ☒ Dispense EPINEPHrine x 2: ☐ 1mg vial ☐ Pen 1mg ☐ Pen JR 0.15mg ☐ Other medication:_____

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: _____