Remicade® Referral Form

PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com ☐ ***Initial Order*** ☐ ***Reorder***

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell

Height: _____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN:_____

Allergies: _____ ☐ **NKDA**

Diagnosis Information: ☐ Crohn's of small intestine w/o complications K50.00 ☐ Crohn's disease of large intestine without complications K50.10 ☐ Crohn's of small and large intestine without complications K50.80 ☐ Ulcerative Colitis without complications K51.90 ☐ Other Diagnosis/ICD10Code_____-

Date Infusion to Begin: _____

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _____

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: _____

List of Failed Therapies: _____

Assessment Questions : *Please Provide Appropriate Documentation*

Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No

Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No

Date of Negative TB test: _____

Remicade® (Infliximab): J1745

☐ 5 mg/kg or _____ mg/kg IV at 0, 2, 6 weeks followed by a dose every 8 weeks for _____months. Titrate per IVCO policy

☐ 3 mg/kg or _____ mg/kg IV at 0, 2, 6 weeks followed by a dose every 8 weeks for _____ months. Titrate per IVCO policy

☐ Maintenance dose: 5mg/kg or _____ mg/kg IV every _____ weeks for _____months. Titrate per IVCO policy

FOR RA: *Is patient also taking methotrexate*? ☐ Yes ☐ No *If not, please document reason:* _____

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion.

Pt. to receive 50ml of a 50ml bag of NS pre- and post- infusion.

☐ Benadryl 25 MG PO x1 ☐ Benadryl 50 mg PO x1

☐ Acetaminophen 325 mg PO x1 ☐ Acetaminophen 650 mg PO x1

☐ Other Pre-medication: _____

Access: ☐ **PIV** ☐ **PORT** ☐ **PICC** **Route:** ☐ **IV**

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5ml: Qty 3

PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml: Qty 3, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 1 per infusion
Catheter Care Supplies (A4221) – 1 per week
Infusion Pump (E0781)
Nursing services to administer medications

Administration through an in-line 1.2-micron or less, sterile, nonpyrogenic, low-protein binding filter is required

Administer the anaphylaxis protocol for adverse reactions.

Provider signature: _____

NPI # _____ Phone _____ Fax _____

Office Address: _____ City: _____ St ___ Zip: _____

Printed MD Name: _____ Contact Name: _____

☐ Demographic information ☐ Patient Ins. Card ☐ H & P ☐ Office notes ☐ Failed therapies in documentation

☐ Up to date medication list

9/23 TSP