Remicade Biosimilar Referral Form

PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com ☐ ***Initial Dose*** ☐ ***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: ☐ Ulcerative Colitis K51.90 ☐ Crohn's Disease small intestine K50.00
☐ Plaques Psoriasis L40 _____ ☐ Psoriatic Arthritis L40.53 ☐ Rheumatoid Arthritis M05.79
☐Ankylosing Spondylitis M45.0 ☐ 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: _____

☐ **Inflectra®:(infliximab-Dyyb)Q5103** ☐ **Avsola®(infliximab-axxq)Q5121**
☐ **Renflexis®(infliximab-abda)Q5104** ☐ **Other Biosimilar**_____ ☐ ***Insurance to Dictate***
☐ 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
☐ **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 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