ARJ Infusion SERVICES *Specialty Pharmacy & High-Tech Nursing*

FAX completed form to ARJ (877) 451-8955
Intake Specialist (866) 451-8804
**referral@arjinfusion.com**
arjinfusion.com/referrals

# **Remicade** Patient Referral Form

**Patient Name:** _____ **Date:** _____

SSN#: _____ DOB: _____ Primary Phone: _____ Work Phone: _____

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

**Primary Diagnosis:** ***Please fill in appropriate ICD-10 code, see reverse side for all ICD-10 codes***

- ☐ **Rheumatoid Arthritis** _____
- ☐ **Ulcerative colitis, unspecified complications** _____
- ☐ **Ankylosing Spondylitis of unspecified sites in spine** _____
- ☐ **Psoriasis** _____
- ☐ **Psoriatic arthritis mutilans** _____
- ☐ **Crohn's disease** _____
- ☐ **Other ICD-10** _____

## 1 Patient Information: *In order to service your patient and facilitate insurance authorization, please complete the following.*

☐ NKDA Allergies: _____

Ht: _____ in/cm Wt: _____ lbs/kg Male ☐ Female ☐

Is this the first Remicade infusion: Yes ☐ No ☐

Date of last infusion: _____ Next dose due: _____

Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other: _____ Lumen #: _____

**Attach documents to FAX** *(see below)*

- ☒ Copy of insurance card
- ☒ Patient demographics
- ☒ Labs
- ☒ H&P
- ☒ Immunization results, include HBV and TB

Other: _____

## 2 Clinical Information: *ARJ policies and protocols to be provided upon request.*

| Initial Dosing | Maintenance Dosing | Directions | Quantity/Refills |
|---|---|---|---|
| ☐ **Remicade** 3 mg/kg IV at week 0, 2, and 6<br>☐ **Remicade** 5 mg/kg IV at week 0, 2 and 6<br>☐ Remicade: _____ | ☐ _____ mg/kg IV every _____ weeks *(rounded to nearest vial size)*<br>☐ Other: _____ | Infuse per manufacturer guidelines **OR** over _____ hours (may not be less than 2 hours.) | Dispense: 1 month supply on all selected medications Refill x12 months unless otherwise noted<br>☐ *Other:* _____ |

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

☐ **Give premedication 30 minutes prior to infusion** *(Note: If nothing is checked, no premeds will be given)*

Diphenhydramine: ☐ 25-50 mg po **OR** ☐ 50 mg IV diluted in D5W or NS 50-100mL, infuse over 10-15 mins.

Antihistamine: ☐ Fexofenadine 180 mg po **OR** ☐ Cetirizine 10 mg po

Methylprednisolone: ☐ 125 mg slow IV push over 5 mins. **OR** ☐ _____ mg slow IV push over 5 mins.

Acetaminophen: ☐ 325-650 mg po **OR** ☐ _____ mg po

☐ D5W or NS 500mL - 1L IV over 30 minutes - 1 hour as tolerated daily PRN for hydration and/or headache (not to run concurrently with Remicade infusion)

☐ Other: _____

☒ RN to monitor patient for minimum of 30 minutes post infusion. RN to educate patient on possible side effects, allergic reactions, and when to contact physician.

☒ RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take Diphenhydramine 25-50 mg po and Acetaminophen 325-650 mg po every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache.

**Adverse Reaction Orders:** *(Dispense 1 dose of each medication below)*

In the event of an infusion reaction (*ie: fever, chills, backache, headache*) the following orders will be followed and physician will be notified.

**Note: For mild reactions, patient may be treated, and infusion resumed at a slower rate.**

☒ **STOP** infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping infusion does not resolve symptoms:

☒ **Diphenhydramine** 50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes or 50 mg/10 mL NS IV push over 2-3 minutes, as tolerated.

☒ **Methylprednisolone** 125 mg (**OR** _____ mg) slow IV push over 5 minutes.

☒ **Acetaminophen** 325-650 mg (**OR** _____ mg) po at onset of symptoms.

☒ **Ondansetron** 4 mg slow IV push over 5 minutes or 4 mg ODT.

☒ **Epinephrine** pen by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used.

## 3 Prescriber Information: *By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.*

Physician Name: _____ Office Contact: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

License #: _____ DEA#: _____ NPI #: _____

_____ Date: _____ | _____ Date: _____

***Physician Signature Required - Substitution Permitted*** ***Physician Signature Required - Dispense as Written***

**Rheumatoid Arthritis**

- ☐ **M05.40** Rheumatoid myopathy with rheumatoid arthritis of unspecified site
- ☐ **M06.9** Rheumatoid Arthritis, unspecified

**Psoriatic arthritis mutilans**

- ☐ **L40.52** Psoriatic arthritis mutilans

**Ulcerative colitis**

- ☐ **K51.919** Ulcerative colitis, unspecified with unspecified complications

**Crohn's disease**

- ☐ **K50.819** Crohn's disease of both small and large intestine with unspecified complications
- ☐ **K50.80** Crohn's disease of both small and large intestine without complications
- ☐ **K50.019** Crohn's disease of small intestine with unspecified complications
- ☐ **K50.919** Crohn's disease, unspecified, with unspecified complications
- ☐ **K50.90** Crohn's disease, unspecified, without complications
- ☐ **K50.10** Crohn's disease of large intestine without complications

**Ankylosing Spondylitis**

- ☐ **M45.9** Ankylosing spondylitis of unspecified sites in spine

**Psoriasis**

- ☐ **L40.0** Psoriasis vulgaris
- ☐ **L40.9** Psoriasis, unspecified

☐ Other: _____

_____

_____

_____