PRIMERA SPECIALTY
INFUSION

INFLIXIMAB
AVSOLA, IXIFI,INFLECTRA, REMICADE,RENFLEXIS
REFERRAL FORM

Patient Name _____
Date of Birth _____
Gender at Birth ◯ Male ◯ Female
Address _____
City, State, Zip _____
Phone _____
Email _____
Primary Insurance _____
Secondary Insurance _____

Prescriber Name _____
NPI # _____ DEA # _____
State Lic # _____ UPI # _____
Practice Name _____
Address _____
City, State, Zip _____
Office Contact _____
Office Contact Phone _____
Office Contact Email _____

CLINICAL INFORMATION

Primary Diagnosis/ICD10 _____
Diagnosis Date _____
Current Therapy _____
Current Directions _____
Prior Therapies/Duration of Use _____
Access Type ☐ Peripheral IV ☐ PICC ☐ Implant Port ☐ Broviac/Hickman
Last Dose _____ Next Dose _____
Negative HBV ☐ Yes ☐ No Date of Test: _____
Negative TB ☐ Yes ☐ No Date of Test: _____
Weight _____ Height _____
Allergies _____

PRESCRIPTION INFORMATION

Medication	☐ **AVSOLA®** ☐ **INFLECTRA®** ☐ **IXIFI®** ☐ **REMICADE®** ☐ **RENFLEXIS®** ☐ **BIOSIMILAR PER PAYER PREFERENCE**
Directions	☐ **Crohn's Disease & UC (Peds)** Dose: 5mg/kg _____mg/kg Total dose:_____ **mg** Quantity: **1** Refills: **1 year** Directions:_____ **mg intravenously every 0, 2, 6 weeks then every 8 weeks** ☐ **Crohn's Disease (Adult) LOR** Dose: 10mg/kg _____mg/kg Total dose:_____ **mg** Quantity: **1** Refills: **1 year** Directions:_____ **mg intravenously every 8 weeks** ☐ **Crohn's Disease & UC (Adult)** Dose: 5mg/kg _____mg/kg Total dose:_____ **mg** Quantity: **1** Refills: **1 year** Directions:_____ **mg intravenously every 0, 2, 6 weeks then every 8 weeks** ☐ **Rheumatoid arthritis (IR)** Dose: 10mg/kg _____mg/kg Total dose:_____ **mg** Quantity: **1** Refills: **1 year** Directions:_____ **mg intravenously every** ☐ **4 weeks** ☐ **6 weeks** ☐ **8 weeks** ☐ **Rheumatoid arthritis** Dose: 3mg/kg _____mg/kg Total dose:_____ **mg** Quantity: **1** Refills: **1 year** Directions:_____ **mg intravenously every 0, 2, 6 weeks then every 8 weeks** (Methotrexate to be ordered separately) ☐ **Ankylosing spondylitis** Dose: 5mg/kg _____mg/kg Total dose:_____ **mg** Quantity: **1** Refills: **1 year** Directions:_____ **mg intravenously every 0, 2, 6 weeks then every 6 weeks** ☐ **Plaque Psoriasis** ☐ **Psoriatic arthritis** Dose: 5mg/kg _____mg/kg Total dose:_____ **mg** Quantity: **1** Refills: **1 year** Directions:_____ **mg intravenously every 0, 2, 6 weeks then every 6 weeks** **Administration Rate:** ☑ Per Prescribing Information, as tolerated ☐ Other: _____
Pre-Medications	☑ Acetaminophen **650mg** 30 minutes prior to infusion PO ☑ Diphenhydramine **25mg** 30 minutes prior to infusion PO ☐ Solu-Cortef _____mg slow IVP ☐ Solu-Medrol _____mg slow IVP Administered: ☐ Pre ☐ Halfway ☐ Upon Completion
Anaphylaxis Orders and Medications	Orders: 1. Stop Infusion 2. Call 911 and prescribing physician 3. Administer medications per protocol Diphenhydramine 50mg/mL slow IVP/IM Administer 12.5mg (wt.<15kg), Administer 25mg (wt.15-30kg) Administer 50mg (wt. > 30kg) Qty 1 Epinephrine 1mg/mL– Administer___ mg (wt. < 15kg) IM, Administer 0.15mg (wt. 15-30kg) IM, Administer 0.3mg (wt. > 30kg) IM Qty: 2 Sodium Chloride 0.9% – Administer 250mL IV at KVO (20ml/hr)
Flushing Protocol	☑ Sodium Chloride 0.9% 5-10mL pre and post medications ☐ Heparin_____Units/mL _____mL as needed
Pump and Ancillary Supplies	☑ Pump and supplies as needed for administration and appropriate disposal of infusion materials
Skilled Nursing Visits	☑ As needed for IV access, administration and appropriate clinical monitoring

In order for brand name product to be dispensed when generic is available, prescriber must handwrite "Dispense As Written" to prohibit substitution. By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Primera Specialty Infusion to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for patient listed above. I understand that I can revoke this designation by providing notice to Primera Specialty Infusion. Mail 795 Primera Blvd, Ste 1011, Lake Mary, FL 32746 Phone (689) 303-3338 Fax (689) 303-3240

Prescriber Signature _____ Date _____