



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____		Prescriber Name: _____	
Address: _____		State License: _____	
City, State, Zip: _____		NPI #: _____ DEA: _____	
Phone: _____ Alt. Phone: _____		Address: _____	
Email: _____ SS#: _____		City, State, Zip: _____	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____		Phone: _____ Fax: _____	
Allergies: _____		Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – AND – Send a copy of the patient’s prescription/insurance cards (front & back)			
Primary Insurance: _____		RX Card (PBM): _____	
City, State, Zip: _____		BIN: _____ PCN: _____	
Plan #: _____		City, State, Zip: _____	
Group #: _____		Group #: _____	
Phone: _____		Phone: _____	
CLINICAL INFORMATION			
<input type="checkbox"/> K51.90 Moderate to Severe Ulcerative Colitis <input type="checkbox"/> K50.90 Moderate to Severe Crohn’s Disease <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> L40.52 Psoriatic Arthritis <input type="checkbox"/> L40.0 Plaque Psoriasis <input type="checkbox"/> Other: _____		*If PPD test results are not within 12 months, please perform PPD. Tuberculosis Screening: <input type="checkbox"/> PPD Test Date: ____-____-____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive → <input type="checkbox"/> Chest X-Ray Performed Date: ____-____-____ X-Ray Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive → TB treatment Initiated	
Labs:			
<input type="checkbox"/> CBC q: _____ <input type="checkbox"/> CMP q: _____ <input type="checkbox"/> CRP q: _____ <input type="checkbox"/> ESR q: _____ <input type="checkbox"/> LFTs q: _____ <input type="checkbox"/> X-Ray: _____ <input type="checkbox"/> Other: _____			
REMICADE®			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Infusion: _____			
Medication	Directions	Quantity/Refills	
Remicade® (infliximab)	<b>Loading dose:</b> <input type="checkbox"/> 5mg/kg _____ mg IV at week: 0, 2, 6 <input type="checkbox"/> 3mg/kg _____ mg IV at week: 0, 2, 6 <input type="checkbox"/> Other: _____ <input type="checkbox"/> <b>Maintenance dose:</b> ( _____ mg/kg) _____ mg IV every _____ weeks	<b>Loading dose:</b> 3 doses. No refills. <b>Maintenance dose:</b> 8-week supply. Refill x 1 year unless noted otherwise. <input type="checkbox"/> _____ week supply Refill x 1 year unless noted otherwise. <input type="checkbox"/> Other: _____	
PRE-MEDICATIONS			
<input type="checkbox"/> Diphenhydramine _____ mg, <input type="checkbox"/> PO -or- <input type="checkbox"/> IV, prior to start of infusion <input type="checkbox"/> Acetaminophen 650 mg PO prior to start of infusion <input type="checkbox"/> Prednisone _____ mg, PO -or- <input type="checkbox"/> Methylprednisolone 40 mg IVP -or- <input type="checkbox"/> Hydrocortisone 100 mg IVP <input type="checkbox"/> Other: _____			
ANAPHYLACTIC REACTION (AR):			
<input type="checkbox"/> EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary <input type="checkbox"/> Hydrocortisone 100mg - Give 100 mg IVP -or- IM if no IV access <input type="checkbox"/> Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr <input type="checkbox"/> Other: _____			

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.



**IV ACCESS**

- Start PIV if no IV access available
- Maintain current central line access

**MONITORING PARAMETERS**

- Obtain vital signs and temperature every 15 mins for the 1st hour, then every 30 mins for the remainder of the infusion
- Observe patient for 30 mins following the infusion
- Instruct patient to report symptoms of chills, fever, headache, sore throat, pain, etc.
- Other: \_\_\_\_\_

**CATHETER CARE**

- Sodium Chloride 0.9% \_\_\_\_\_ mL IV before and after each IV access and PRN per protocol
- Sodium Chloride 0.9% \_\_\_\_\_ mL as above AND Heparin 100 Units /mL \_\_\_\_\_ mL IV flush after second saline flush and PRN
  - Dressing changes weekly and PRN
  - Antimicrobial dressing PRN
  - May obtain blood from IV access for labs
  - May use Cathflo 2 mg/2 mL sterile water IVP 2 mL per lumen; May repeat after 2 hours x 1

**STANDARD ORDER FOR SIDE EFFECTS**

- Promethazine 25 mg – 1-2 tabs po q 4-6 hrs PRN nausea / vomiting
- Acetaminophen 325 mg - 2 tabs po q 4-6 hrs PRN HA, myalgia, fever
- Promethazine 25 mg IV/IM x 1 dose PRN nausea / vomiting
- Diphenhydramine 25 mg - 1 to 2 caps po PRN
- Diphenhydramine 25 mg -or- 50 mg IV x 1 dose PRN
- Other: \_\_\_\_\_

**SIGNATURE**

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral

X \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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