INFLIXIMAB (REMICADE) PRESCRIPTION REFERRAL FORM

MEMORIAL HERMANN Home Care

Please sign and fax completed form to 281.698.6147
If you have questions, please call 281.698.6175

PATIENT INFORMATION

Patient Name:	DOB:
Street Address:	☐ Male ☐ Female
City, State, ZIP:	
Primary Phone:	Alt. Phone:
Email Address:	Patient's primary language:

PRESCRIBER INFORMATION

Prescriber Name:	☐ MD ☐ DO ☐ NP ☐ P
Specialty:	NPI #:
Office Contact:	DEA #:
Email:	
Phone:	Fax:
Office Address:	Preferred Method of Contact ☐ Email ☐ Phone ☐ Fax
City, State, ZIP:	

CLINICAL INFORMATION

Diagnosis (ICD-10)	**Medical Information**
Primary ICD: Description:	Type of Access to be used:
Other ICD: Description:	Allergies:
Treatment History	Current weight:__________ kg / height:__________ cm
Has patient been treated previously for this condition? ☐Yes ☐No	Please include copy of current medication profile if available.
Will this be a first does? ☐ Yes ☐ No	

PRESCRIPTION INFORMATION

☐ Home Health to evaluate and treat for Infliximab infusion

Pre-Medications To be administered 30 minutes prior to starting the infusion.

☐Tylenol _________mg by mouth ☐ Antihistamine: (please choose one) ______mg Benadryl by mouth ______mg Benadryl IV or ____mg Loratadine by mouth

Additional Pre-Medication Orders:

☐ Solu-Medrol _______mg IV push ☐ ______________________________________ ☐ ______________________________________

Infliximab (Remicade) ☐initiation dose ___mg/kg at weeks 0, 2 & 6 ☐maintenance dose ___mg/kg every 8 weeks ☐other: ___mg/kg every ___weeks ☐Refill:_____

Start infusion at 10mL per hour and increase if tolerated after 15 minutes

- Continue to titrate the infusion as tolerated using the following infusion rates: 20mL/hr x 15 minutes, 40mL/hr x 15 minutes, 80mL/hr x 15 minutes, 150mL/hr x 30 minutes
- Maximum infusion rate of no more than 250mL/hr
- Infusion time should not be less than 2 hours
- DO NOT infuse any other medications along with the Infliximab

Line Care ☐ Flush with 10ml 0.9% Sodium Chloride before and after medication administration.

☐ Other Line Care: ____

Laboratory Work and Frequency ____

Reaction Management STOP infusion immediately. Administer reaction management medications.

- Acetaminophen (Tylenol) 500MG by mouth every 4 hours PRN myalgia or fever > 101.3.
- Diphenhydramine (Benadryl) 25MG IV every 4 hours PRN urticarial, pruritus, or shortness of breath.
- If symptoms are rapidly progressing or continue after the diphenhydramine: give epinephrine (1:1,000 strength) 0.3mL subcutaneously. May repeat every 10-15 minutes at a maximum of 6 doses.
- Other: ____

Notify Physician immediately for any new onset of the following life threatening hypersensitivity reactions to include fever, chills, dyspnea, pruritus, urticarial, convulsions, erythematous rash, hypotension, back pain, sudden chest pain or hypertension.

Call 911 as appropriate

By signing below, I authorize Memorial Hermann Home Health Pharmacy and its representatives to serve as my designated agent if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies.

Prescriber's Signature:____ Date:____________

(signature required – NO STAMPS)

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