Biologics referral form

Optum

Optum Infusion Pharmacy Phone: _____ Fax: 877-542-9352 or _____

✂ Please detach before submitting to a pharmacy – tear here.

Care specialist Name: _____ Phone: _____

Patient information

☐ see attached ☐ PEDIATRIC (younger than 13 years or less than 45 kg in weight)

Patient name: _____ Gender: ○ M ○ F DOB: _____ Last 4 of SSN: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Cell: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Insurance: ☐ Front and back of insurance card is attached

Primary Insurance: _____ Phone: _____ Policy #: _____ Group: _____

Secondary Insurance: _____ Phone: _____ Policy #: _____ Group: _____

Medical assessment: Height in inches: _____ Weight in kg only: _____ Date weight (in kg) obtained: _____

Primary diagnosis: ☐ ICD10 Code: _____ Diagnosis: _____

Current medications? ○ Yes ○ No If yes, list or attach: _____

Allergies: _____

TB test: ☐ Negative ☐ Positive, test date _____ ☐ No TB test in past year. Fax clinical notes of most recent screening.

For infliximab therapy, include documentation of HBV vaccination and/or HBV test(s) with fax.

Tried and failed therapies: Include supportive clinical documents ☐ 5-Aminosalicyclic Acid Agents ☐ 6-Mercaptopurine ☐ Azathioprine ☐ Corticosteroids ☐ Etanercept ☐ Adalimumab ☐ Methotrexate ☐ NSAIDS ☐ Other: _____

☐ Patient requires a first lifetime dose and is to receive the first dose in the home or Optum Ambulatory Infusion Suite.

☐ IV access (if IV therapy is prescribed): ☐ PIV ☐ PICC ☐ Port ☐ Midline ☐ Tunneled CVC; number of lumens: _____

Date of IV placement: _____ Date of last IV service (flush and/or dressing change): _____

Medication prescriptions and orders

Medication infused per the drug PI recommended rate and via rate controlled device per therapy

Medication	**Dose and directions** (select desired dose(s) and indicate relevant dates)
Vedolizumab (Entyvio), x1 year Adult Ulcerative Colitis and Crohn's Disease	First Dose: ○ YES ○ NO If NO, indicate when next dose is needed: Induction Dose: Week 2, Date Due: _____ Week 6, Date Due: _____ Maintenance Dose: Date Due: _____ ☐ IV Induction Dose: Infuse 300 mg IV at weeks 0, 2 and 6 ☐ Other _____ ☐ IV to Sub-Q Induction dose: Infuse 300 mg IV at weeks 0 and 2 ☐ Other _____ ☐ IV Maintenance Dose: Infuse 300 mg IV every 8 weeks ☐ Other _____ ☐ Sub-Q Maintenance dose: Inject 108 mg subcutaneously at week 6 then every 2 weeks thereafter ☐ Other _____
Ustekinumab (Stelara), x1 year Adult Ulcerative Colitis and Crohn's Disease	First Dose: ○ YES ○ NO If NO, indicate when next SC dose is needed: Date Due: _____ ☐ Intravenous Induction Dose: ○ Patients weighing ≤ 55 kg: Infuse 260 mg (2 x 130 mg / 26 mL vials) IV at week 0 ○ Patients weighing > 55 kg: to 85 kg: Infuse 390 mg (3 x 130 mg / 26 mL vials) IV at week 0 ○ Patients weighing > 85 kg: Infuse 520 mg (4 x 130 mg / 26 mL vials) IV at week 0 ☐ Sub-Q Maintenance Dose: Inject 90 mg subcutaneously every 8 weeks
Infliximab (Remicade; Inflectra; Renflexis; Avsola), x1 year Adult and Pediatric Crohn's Disease and Ulcerative Colitis; Adult Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Plaque Psoriasis.	☐ No infliximab product preference ☐ Preferred product: _____ First Dose: ○ YES ○ NO If not a first dose, when is next dose due? Induction Dose: Week 2, Date Due: _____ Week 6, Date Due: _____ Maintenance Dose: Date Due: _____ ☐ Induction Dose: Infuse 5 mg / kg or _____ mg / kg IV at weeks 0, 2 and 6 ☐ Maintenance Dose: Infuse _____ mg / kg IV every 8 weeks OR _____ mg / kg IV every _____ weeks Infusion time: Infuse over _____ hours if different than PI recommendation Doses will be rounded to the nearest 100 mg vial, or nearest 10 mg vial for doses < 101 mg, unless specified otherwise by the prescriber. _____

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Medication prescriptions and orders

Medication infused per the drug PI recommended rate and via rate controlled device per therapy

Medication	Dose and directions (select desired dose(s) and indicate relevant dates)
Risankizumab (Skyrizi), x1 year Adult Ulcerative Colitis and Crohn's Disease	First Dose ○ YES ○ NO If NO, indicate when next dose is needed: Induction Dose: Week 4, Date Due: _____ Week 8, Date Due: _____ Maintenance Dose: Date Due: _____ ☐ CD Intravenous Induction Dose: Infuse 600 mg IV at weeks 0, 4 and 8. ☐ UC Intravenous Induction Dose: Infuse 1200 mg IV at weeks 0, 4, and 8. Sub-Q Maintenance Dose (select one): ☐ 180 mg cartridge ☐ 360 mg cartridge with on-body injector. Inject subcutaneously at week 12 and then every 8 weeks thereafter.
Mirikizumab-mrkz (Omvoh), x1 year Adult Ulcerative Colitis	Induction Dose: Week 4, Date Due: _____ Week 8, Date Due: _____ Maintenance Dose: Date Due: _____ ☐ Induction Dose: Infuse 300 mg IV at weeks 0, 4, and 8 Other: _____ Sub-Q Maintenance Dose: Inject two consecutive 100 mg doses (200 mg total) starting at week 12 and every 4 weeks thereafter

Prescriptions and ancillary orders

Premedication (select below): Dispense PRN x 1 year.

	Drug	Patient Type	Dose	Dispense detail	Directions
☐	**DiphenhydrAMINE**	Adult & Pediatric > 30 kg	50 mg (two 25 mg capsules or tablets)	Dispense 25 mg capsules or tablets #100	Administer orally 30 minutes prior to Biologic medication. May repeat once if symptoms occur.
		Pediatric 15 - 30 kg	25 mg (10 mL)	Dispense 2.5 mg / mL oral solution #120 mL (300 mg)	
		Pediatric < 15 kg	12.5 mg (5 mL)	Dispense 2.5 mg / mL oral solution #120 mL (300 mg)	
☐	**Acetaminophen**	Adult & Pediatric > 30 kg	325 mg	Dispense 325 mg tablets or 325 mg (10.15 mL) unit dose oral solution #100.	Administer orally 30 minutes prior to Biologic medication. May repeat once if symptoms occur.
		Pediatric 15 - 30 kg	160 mg (5 mL)	Dispense 160 mg (5 mL) tablets #30 or 32 mg / mL oral solution 120 mL.	
		Pediatric < 15 kg	80 mg (2.5 mL)	Dispense 32 mg / mL oral solution 120 mL.	
☐	**Other, specify** _____	_____	_____	_____	_____

Lab Orders, x1 year	☐ Albumin ☐ ALT ☐ AST ☐ CBC w/diff ☐ SCr/BUN ☐ CM ☐ CRP ☐ ESR ☐ LFT ☐ Platelets ☐ Other _____ Frequency of labs: _____ Lab work to be obtained via IV access using aseptic technique. If RN is not able to draw labs from a central catheter, the labs may be drawn peripherally. RN to flush IV access after each blood draw with 0.9% Sodium Chloride 20 mL. As final lock for patency, use Heparin 10 units / mL, 5 mL, or if Port use Heparin 100 units / mL, 5 mL.

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Prescriptions and ancillary orders

Nursing Orders, x1 year	RN to administer prescribed medication. If subcutaneous therapy ordered, RN to teach administration via Sub-Q injection for maintenance therapy. RN to insert/maintain/remove peripheral IV (PIVC) or access central venous catheter (CVC) as needed using aseptic technique. RN to rotate PIVC as needed for signs of infiltration/irritation. Flush PIVC with 0.9% Sodium Chloride 5 mL pre infusion and post infusion. Flush infusion set following infusion of Entyvio with 0.9% Sodium Chloride using sufficient volume to ensure that all medication has been administered (25 - 30 mL is adequate for most infusion sets). If needed for CVC, lock IV access for patency with heparin 10units / mL 3 mL. If port, RN to access with non-coring port needle using sterile technique. De-access after infusion and apply sterile pressure gauze and transparent dressing to site. RN to use sterile field 0.9% Sodium Chloride 10mL with needle change. Flush port with 0.9% Sodium Chloride 10mL pre infusion and post infusion. Flush infusion set following infusion of Entyvio with 0.9% Sodium Chloride using sufficient volume to ensure that all medication has been administered (25 - 30 mL is adequate for most infusion sets). Flush port on treatment day, at least every 8 weeks, and PRN to maintain line patency. Use heparin 100 units / mL 5 mL as final lock for patency. Discontinue port maintenance upon discontinuation of pharmacy services.
Pharmacy Orders, x1 year	Pharmacy to dispense flushes, needles, syringes and HME/DME quantity sufficient to complete therapy as prescribed.

☑ **Anaphylaxis/infusion reaction management orders:** Dispense PRN x 1 year

Drug	Patient Type	Dose	Dispense detail	Directions
DiphenhydrAMINE	Adult & Pediatric > 30 kg	50 mg	Dispense 25 mg capsules or tablets #4 Dispense 50 mg vial for injection #1	For mild* symptoms, slow infusion 50% until symptoms resolve. Administer diphenhydrAMINE PO. For moderate* to severe* symptoms, stop infusion. Administer diphenhydrAMINE slow IV push not to exceed rate of 25mg/min. May repeat x1 if symptoms persist. For moderate* symptoms, resume infusion at 50% previous rate IF symptoms resolve.
	Pediatric 15 - 30 kg	25 mg	Dispense 25 mg / 10 mL oral solution 120 mL Dispense 50 mg vial for injection #1	
	Pediatric < 15 kg	12.5 mg	Dispense 12.5 mg / 5 mL oral solution 120 mL Dispense 50 mg vial for injection #1	
EPINEPHrine	Adult & Pediatric > 30 kg	0.3 mg / 0.3 mL	Dispense 1mg vial for injection #2	For severe* symptoms (anaphylaxis), stop infusion. Disconnect tubing from access device to prevent further administration. Activate 911. Administer EPINEPHrine IM into lateral thigh x1. May repeat in 5-15 minutes if symptoms persist. Administer CPR if needed until EMS arrives. Contact prescriber to communicate patient status.
	Pediatric 15 - 30 kg	0.15 mg / 0.15 mL	Dispense 1mg vial for injection #2	
	Pediatric 7.5 - 15 kg	0.1 mg / 0.1 mL	Dispense Autoinjector Pen 0.1 mg (PED) #2	
0.9% Sodium Chloride Injection, USP	Dispense 500 mL bag #1. For severe* symptoms, administer IV gravity bolus (1000 mL / hour).			
Other, specify				

*Mild symptoms include flushing, dizziness, headache, apprehension, sweating, palpitations, nausea, pruritus, and/or throat itching.
Moderate symptoms include chest tightness, shortness of breath, > 20 mmHg change in systolic blood pressure from baseline, and/or increase in temperature (> 2°F).
Severe symptoms include > 40 mmHg change in systolic blood pressure from baseline, increase in temperature with rigors, shortness of breath with wheezing, and/or stridor.

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Patient name: _____ DOB: _____

Physician information

Name: _____ Practice: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ NPI: _____ Contact: _____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

_____ _____ _____

Substitution permissible signature | Dispense as written signature | Date

Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and labs ☐ TB and HBV screening

Please include ALL 4 pages of referral form and additional documentation when faxing.

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