Biologics referral form

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 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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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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