TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

REMICADE®

Please Fax Completed Form To: **888-898-9113**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
City, State, Zip: _____
Plan #: _____
Group #: _____
Phone: _____

RX Card (PBM): _____
BIN: _____ PCN: _____
City, State, Zip: _____
Group #: _____
Phone: _____

CLINICAL INFORMATION

☐ K51.90 Moderate to Severe Ulcerative Colitis
☐ K50.90 Moderate to Severe Crohn's Disease
☐ M06.9 Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ L40.52 Psoriatic Arthritis
☐ L40.0 Plaque Psoriasis
☐ Other: _____

*If PPD test results are not within 12 months, please perform PPD.
Tuberculosis Screening: ☐ PPD Test Date: _____-_____-_____
Results: ☐ Negative
☐ Positive → ☐ Chest X-Ray Performed Date: ____-_____-_____
X-Ray Results: ☐ Negative
☐ Positive → TB treatment Initiated

Labs:
☐ CBC q: _____ ☐ CMP q: _____ ☐ CRP q: _____ ☐ ESR q:_____ ☐ LFTs q: _____ ☐ X-Ray: _____ ☐ Other: _____

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Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Infusion: _____

Medication	Directions	Quantity/Refills
Remicade® (infliximab)	**Loading dose:** ☐ 5mg/kg _____ mg IV at week: 0, 2, 6 ☐ 3mg/kg _____ mg IV at week: 0, 2, 6 ☐ Other: _____ ☐ **Maintenance dose:** (_____ mg/kg) _____ mg IV every _____ weeks	**Loading dose:** 3 doses. No refills. **Maintenance dose:** 8-week supply. Refill x 1 year unless noted otherwise. ☐ _____ week supply Refill x 1 year unless noted otherwise. ☐ Other: _____

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg 100mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion
☐ _____	_____	_____

INFUSION REACTION ORDERS

Mild reaction protocol:

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☒ Diphenhydramine 25mg IV, one time, for pruritus.

If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors

☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

☒ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis

☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

☒ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:	**Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:**
☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:	**PICC:**	**Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:**
☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused**

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_____ Date: _____

Prescriber Signature

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.