Biologics referral form

Optum Infusion Pharmacy Phone: Fax:

✂ 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 45kg 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:

Primary diagnosis: ☐ ICD10 Code: Diagnosis:

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

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 ☐ Enbrel ☐ Humira ☐ Methotrexate ☐ NSAIDS ☐ Other:

Prescription 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)
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: ☐ Induction Dose: Infuse 300mg IV at weeks 0, 2 and 6 ☐ Other ☐ Maintenance Dose: Infuse 300mg IV every 8 weeks ☐ Other
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 x130mg/26ml vials) IV at week 0 ○ Patients weighing > 55 kg to 85 kg: Infuse 390 mg (3 x 130mg/26ml vials) IV at week 0 ○ Patients weighing > 85 kg: Infuse 520 mg (4 x 130mg/26ml vials) IV at week 0 ☐ SC Maintenance Dose: Inject 90mg SC 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 5mg/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 100mg vial, or nearest 10mg vial for doses <101mg, unless specified otherwise by the prescriber.
Skyrizi, x1 year Moderately to severely active Crohn's disease in adults	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: ☐ Intravenous Induction Dose: Infuse 600mg IV at weeks 0, 4 and 8. SC Maintenance Dose (select one): ☐ 180mg cartridge ☐ 360mg cartridge with on-body injector. Inject subcutaneously at week 12 and then every 8 weeks thereafter.

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Prescriptions and ancillary orders

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

	Drug	Patient Type	Dose	Dispense detail	Directions
☐	**DiphenhydrAMINE**	Adult & Pediatric >30kg	50 mg	Dispense 25mg capsules or tablets #100	Administer PO 30 minutes prior to Biologic medication. May repeat x1 if symptoms occur.
		Pediatric 15-30kg	25 mg	Dispense 25mg/10ml oral solution 120 ml	
		Pediatric <15kg	12.5 mg	Dispense 12.5mg/5ml oral solution 120ml	
☐	**Acetaminophen**	Adult & Pediatric >30kg	325 mg	Dispense 325mg tablets #100 or 325mg/10.15ml UD oral solution #30	Administer PO 30 minutes prior to Biologic medication. May repeat x1 if symptoms occur.
		Pediatric 15-30kg	160 mg	Dispense 160mg tablets #30 or 160mg/5ml oral solution 120ml	
		Pediatric <15kg	80 mg	Dispense 80mg/2.5ml oral solution 120ml	
☐	**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 Sodium Chloride 0.9% 20 mL. As final lock for patency, use Heparin 10 units/mL, 5mL, or if Port use Heparin 100 units/mL, 5mL.
Nursing Orders, x1 year	RN to administer prescribed medication. If Stelara or Skyrizi are ordered, RN to teach self-administration via SC 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 Sodium Chloride 0.9% 5mL 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 3mL. 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 Sodium Chloride 0.9% 10mL with needle change. Flush port with Sodium Chloride 0.9% 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 once monthly, and PRN to maintain line patency. Use heparin 100units/mL 5mL 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.

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

Drug	Patient Type	Dose	Dispense detail	Directions
DiphenhydrAMINE	Adult & Pediatric >30kg	50 mg	Dispense 25mg capsules or tablets #4 Dispense 50mg 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 15-30kg	25 mg	Dispense 25mg/10ml oral solution 120 ml Dispense 50mg vial for injection #1	
	Pediatric <15kg	12.5 mg	Dispense 12.5mg/5ml oral solution 120ml Dispense 50mg vial for injection #1	
EPINEPHrine	Adult & Pediatric >30kg	0.3mg/0.3ml	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 15-30kg	0.15mg/0.15ml	Dispense 1mg vial for injection #2	
	Pediatric 7.5-15kg	0.1mg/0.1mL	Dispense Autoinjector Pen 0.1mg (PED) #2	
Sodium Chloride 0.9% Injection, USP	Dispense 500 ml bag #1. For severe* symptoms, administer IV gravity bolus (1000mL/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.

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 3 pages of referral form and additional documentation when faxing.

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