

GI REFERRAL FORM

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:
DATE OF REFERRAL:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:	
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE MALE
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST NKDA

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

1. INSURANCE CARD (Front & Back)
 2. PATIENT DEMOGRAPHICS
 3. MOST RECENT LABS
 4. MEDICATION LIST
 5. TRIED/FAILED THERAPIES
 6. H & P
 TB Results: Quantiferon Gold Lab, CXR, or PPD (Remicade, Inflectra, Entyvio, Stelara only)
 Date of test: _____
 Positive
 Negative

LABS:

Lab Orders:
 CBC
 CBC w/Diff
 CMP
 CRP
 SED Rate
Frequency:
 with each infusion
 every _____ weeks

PRIMARY MEDICATION ORDER:

Remicade:

3 mg/kg IV at weeks 0, 2, 6, and every _____ weeks thereafter.
 5 mg/kg IV at weeks 0, 2, 6, and every _____ weeks thereafter.
 8 mg/kg IV at weeks 0, 2, 6, and every _____ weeks thereafter.
 10 mg/kg IV at weeks 0, 2, 6, and every _____ weeks thereafter.

Biosimilar may be used according to payer guidelines.

Entyvio:

300 mg IV at weeks 0, 2, 6, and every 8 weeks thereafter.
 300 mg IV every _____ weeks.
 300 mg IV once.

Stelara – Induction Dose:

55 kg or less: 260 mg IV once.
 56 kg to 85 kg: 390 mg IV once.
 Greater than 85 kg: 520 mg IV once.

Stelara – Maintenance Dose:

90 mg subcutaneous injection at week 8 and every 8 weeks thereafter.

Skyrizi – Induction Dose:

600 mg IV at weeks 0, 4, and 8.

Skyrizi – Maintenance Dose:

360 mg subcutaneous injection, via on body device, every 8 weeks
 (beginning at week 12 when using induction dose).

Other: _____

First Dose:
 Y
 N

Refill x12 months unless otherwise noted.

PRN & PRE-MEDICATIONS:

MEDICATIONS	30 minutes prior to every infusion	PRN
Acetaminophen 650 mg PO		PRN every ____ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg PO		PRN every ____ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg IV		PRN every ____ hour for mild or moderate infusion reaction.
Methylprednisolone 125 mg IV		PRN every ____ hour for mild or moderate infusion reaction.
Other: _____		PRN every ____ hour for mild or moderate infusion reaction.

LINE USE/CARE ORDERS:

- START PIV/ACCESS CVC
 FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE)
 OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

- ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)
 OTHER: (please fax other reaction orders if checking this box)

GI REFERRAL FORM

PRIMARY DIAGNOSIS:

- | | |
|---|--|
| K50 - Crohn's disease (regional enteritis) | K50.00 - Crohn's disease small intestine without complications |
| K50.01 - Crohn's disease of small intestine with complications | K50.10 - Crohn's disease of large intestine without complications |
| K50.11 - Crohn's disease of large intestine with complications | K50.80 - Crohn's disease of both small and large intestine w/o complications |
| K50.81 - Crohn's disease of both small and large intestine with complications | K50.90 - Crohn's disease, unspecified, without complications |
| K50.91 - Crohn's disease, unspecified, with complications | K51 - Ulcerative Colitis |
| K51.01 - Ulcerative (chronic) pancolitis with complications | K51.00 - Ulcerative (chronic) pancolitis without complications |
| K51.011 - Ulcerative (chronic) pancolitis with rectal bleeding | K51.019 - Ulcerative (chronic) pancolitis with unspecified complications |
| K51.20 - Ulcerative (chronic) proctitis without complications | K51.21 - Ulcerative (chronic) proctitis with complications |
| K51.31 - Ulcerative (chronic) rectosigmoiditis with complications | K51.311 - Ulcerative (chronic) rectosigmoiditis with rectal bleeding |
| K51.51 - Left-sided colitis with complications | K51.81 - Other ulcerative colitis with complications |
| K51.90 - Ulcerative colitis, unspecified without complications | K51.91 - Ulcerative colitis, unspecified, with complications |
| K51.919 - Ulcerative colitis, unspecified with unspecified complications | |

Other _____

PRESCRIBER INFORMATION: Please check preferred form of communication.

PROVIDER NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	EMAIL:
CITY, STATE, ZIP:	NPI:

(GENERIC SUBSTITUTION PERMITTED)
 PROVIDER SIGNATURE: _____ DATE: _____

(DISPENSE AS WRITTEN)
 PROVIDER SIGNATURE: _____ DATE: _____

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FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	<ul style="list-style-type: none"> Flushing Dizziness Headache Apprehension Diaphoresis Palpitations Nausea / Vomiting Pruitis 	<ul style="list-style-type: none"> Chest Tightness Shortness of Breath Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) Increased Temperature (>2 Degrees Fahrenheit) Urticaria 	<ul style="list-style-type: none"> Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). Increase Temperature (>2 Degrees Fahrenheit) with Rigors Shortness of Breath with Wheezing Laryngeal Edema Chest Pain Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.