HealthQuest
Infusion & Specialty

INFLIXIMAB REFERRAL FORM

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 612-3500 **F** (832) 500-8629

DATE:_____ NEXT TREATMENT DATE:_____

Please fax completed form along with copy of patient's insurance cards and any labs to **(832) 500-8629**

Patient Name _____
Patient Address _____
City _____ State _____ Zip _____
Day Phone _____ Work Phone # _____
Cell Phone _____
Date of Birth _____ ☐ Male ☐ Female
E-mail _____

Prescriber's Name _____
DEA # _____ NPI # _____
Practice Name _____
Office Contact _____
Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

DIAGNOSIS

Patient: Wt._____ Ht._____ Allergies: ☐ Latex ☐ Other, specify _____

ICD-10 DIAGNOSIS CODE ☐ K50.00 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ Other: _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed: _____
Patient currently on therapy? ☐ Yes ☐ No Types/Medications: _____
Current medication, including OTC: _____ **PPD (TB Test):** ☐ Yes ☐ No Date: _____

PRESCRIPTION

INFLIXIMAB: *(choose one)*
- ☐ Infuse Infliximab **OR** infliximab biosimilar as required by patient's insurance
  - **Preferred product to be determined after benefits investigation (noted below)
- ☐ Do not substitute. Infuse the following infliximab product: _____

Dose: _____ **mg/kg**

Frequency:
- ☐ 0, 2, 6 weeks, then every 8 weeks (initial start) x1 year
- ☐ Every _____ weeks (maintenance dose) x1 year
- ☐ Other: _____

Premedication orders: Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Quzyttir 10mg IVP

Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP
☐ Other: _____

Lab orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____
☐ Yearly TB testing QFT (optional) Required labs to be drawn by: ☐ HealthQuest ☐ Referring physician

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): Epinephrine 0.3mg IM or subQ; may repeat in 5–10 minutes x1
  - 15–30kg (33–66lbs): Epinephrine 0.15mg IM or subQ; may repeat in 5–10 minutes x1
- Diphenhydramine: Administer 25–50mg IV (adult)
- NS 0.9% 500mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing and infusion reaction management

Flush orders: NS 1–10mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indiciated PRN

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____

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COMPREHENSIVE SUPPORT FOR INFLIXIMAB THERAPIES

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include **signed** and **completed** order (MD/prescriber to complete page 1)
☐ Include patient demographic information and insurance information
☐ Include patient's medication list
☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindication to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)? ☐ Yes ☐ No
  If YES, which drug(s)? _____
- ☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira®, Enbrel®, Stelara®, Cimzia®)? ☐ Yes ☐ No
  If YES, which drug(s)? _____
- ☐ If psoriasis diagnosis, percent of body surface *BSA(involved: _____ %

☐ Include labs and/or test results to support diagnosis
☐ If applicable - Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a washout period of _____ weeks prior to starting Infliximab.
☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ TB screening test completed within 12 months - **attach results**
- ☐ Positive ☐ Negative

☐ Hepatitis B screening test completed.
This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) patient - **attach results**
- ☐ Positive ☐ Negative

**** If TB or Hepatitis B results are positive, please provide documentation of treatment or medical clearance, and a negative CXR (TB+)***

HealthQuest Infusion & Specialty will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (832) 500-8629 or call (832) 612-3500