Remicade Enrollment Form

FACTOR ONE SOURCE FAST PHARMACY
Powered By: InfuCare Rx

Phone: 1-833-FOS-FAST
Fax: 844-533-1131
Website: www.FOSRXFAST.com
Louisiana Office
2400 Veterans Blvd., Suite 480
Kenner, LA 70062

PATIENT INFORMATION

Name:			
Address:			
City:	State/Zip:		
Telephone:	DOB:	M ☐ F ☐	
Language Preference:	Wt:	Ht:	

PRESCRIBER INFORMATION

Prescribing Practioner:		NPI:
Address:		
City		State/Zip
Office:		DEA:
Contact:	Phone:	Fax:

PRIMARY INSURANCE INFORMATION

Member Name:		M ☐ F ☐	DOB:
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:		

CLINICAL INFORMATION

Diagnosis: _____ (ICD-10) _____
Please attach supporting labs and provide medications list

PRESCRIPTION

Date of next infusion: _____ Current weight: _____lb/kg New ☐ Refill ☐ Ship by: _____

Dose: ☐ 5 mg/kg ☐ 3 mg/kg ☐ _____ mg/kg

REMICADE 100mg vial

Reconstitute each vial with 10ml of sterile water.
Infuse Remicade in 250 ml 0.9% NS using non-pvc tubing and 1.2 micron filter via PIV over a period not less than 2 hours.

☐ Sig: ☐ Loading dose: Administer _____ mg IV on week 0, 2, & 6 (3 doses /Ref: 0)

☐ Maintenance dose: Administer _____ mg IV every _____ weeks

☐ Maintenance dose: 250 ml 0.9% Ns (#1)
Qty: 1 month supply Refill: ___ months

INFUSION SETTING

☐ Infusion Clinic
Name: _____
Phone: _____

☐ Home Infusion
Home health agency: _____
Phone: _____

☐ Our specialty pharmacy to coordinate

☐ Infusion supplies* needed

*All necessary ancillary supplies (needles, syringes, etc.) to establish IV access and administer medication.

Premedications: Sig: pre-medicate 30 min prior to infusion

☐ acetaminophen 325mg po	Qty: 2	Ref: PRN
☐ diphenhydramine 50mg/1ml ivp	Qty: 1	Ref: PRN
☐ diphenhydramine 25mg po	Qty: 2	Ref: PRN
☐ prednisone 10mg po	Qty: 5	Ref: PRN
☐ solu-medrol 40mg slow ivp	Qty: _____	Ref: PRN
☐ _____	Qty: _____	Ref: PRN

Other orders Sig: to be used per nursing agency protocol

☐ solu-medrol 125mg slow ivp Qty: _____ Ref: PRN
☐ phenergan o 25mg o po o ivp Qty: _____ Ref: PRN
☐ _____ Qty: _____ Ref: PRN

Flushing orders ☐ peripheral access ☐ central venous access
Sig: to be used per nursing agency protocol Ref: PRN

☐ heparin flush 10u/ml Qty: _____ 5ml/10ml
☐ heparin flush 100u/ml Qty: _____ 5ml/10ml
☐ saline flush Qty: _____ 5ml/10ml
☐ _____ Qty: _____ Ref: PRN
☐ epinephrine/epipen® Qty: _____ Ref: PRN
Sig: 0.3 Mg im as needed for anaphylaxis, then call 911. Notify physician of type of reaction & action taken. Verbal report & transfer care to ems, if applicable.

☐ _____ Qty: _____ Ref: PRN
☐ _____ Qty: _____ Ref: PRN
☐ _____ Qty: _____ Ref: PRN
☐ Other:

Additional Clinical Information:

Allergies:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: **Date:**