Upstate HomeCare

The Best for Getting Better

Biologics Home Infusion Referral Form
Phone: (877) 286-0800 x 6018
Fax: (315) 580-4297

FAX

To: Upstate HomeCare Intake **Fax#:** (315) 580-4297

Patient Name: **Date of Birth:**

Allergies: **Wgt:**

Referral Checklist - Please Attach the Following

☐ **Demographics/Insurance** ☐ **H&P/Progress Notes/Labs/Medication Profile/Failed Therapies**

Diagnosis Information / Medical Assessment

Diagnosis: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other _____

Has patient received a PPD (tuberculosis) Skin Test or QuantiFeron TB GOLD Test?
Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.

☐ Yes ☐ No Results: _____

Prescription Information

1. Assess patient for signs/symptoms of infection; notify MD if present prior to proceeding

2. Establish Intravenous Access (Peripheral IV) unless patient already has a line (PICC)

3. Infusion Labs: ☐ CBC w/differential ☐ ESR ☐ CMP ☐ CRP ☐ Other: _____

4. Medication: _____ Dose: _____mg/Kg _____mg IV q _____ x 1 year

Flushing

☐ Flush with 3–5mL of Sodium Chloride 0.9% (10mL flush) Qty: 30mL Refills: _____

Pre-Meds

PO: Tablets or Elixir - Patient to obtain

☐ Acetaminophen 650mg tablet OR Acetaminophen 160mg/5mL solution _____
(15mg/kg ONCE PO; max dose 650mg)
For oral tablets round the dose to closest 325 or 650mg

☐ Cetirizine (Zyrtec) 5-10mg tablet OR Cetirizine (Zyrtec) syrup (1mg/1mL) _____
Age <6 years old: Dose 5mg / Age >/= 6 years old: Dose 10mg

☐ Diphenhydramine (Benadryl) 25-50mg tablets OR Diphenhydramine (Benadryl) 12.5mg/5mL Elixir _____
(1mg/kg ONCE PO; max dose 50mg)

IV: Optional based on clinical scenario

☐ Diphenhydramine 50mg/mL - 1mL vial Qty #1
(1.25mg/kg IV; max dose 50mg) _____
Weight <40 kg: Give 1.25mg/kg / Weight >/= 40 kg: Give 50mg

☐ Methylprednisolone 40mg vial Qty #1
(1mg/kg/dose IV; max dose of 40mg) _____
Weight <40 kg: Give 1.25mg/kg / Weight >/= 40 kg: Give 50mg

☐ Hydration - 250mL Bag Sodium Chloride 0.9% @ 50mL/hr Qty #1 _____

Anaphylactic Orders:

☐ IM Epinephrine [1mg/mL preparation = 1:1000] 1mL vial Qty #1
Give 0.01 mg/kg/dose; IM in mid-outer thigh; may repeat every 5 min for 3 doses
Weight <30 kg: Give 0.01mg/kg/dose / Weight >/= 30 kg: Adult dose = 0.3mg = 0.3mL

E-scribe: Upstate HomeCare ☐ Dispense as Written ☐ Substitution Permissible

Ordering Provider: **NPI#:**

Provider Signature: **Date:**

By signing this form, you, as the following physician are authorizing an Upstate HomeCare Pharmacist to transcribe the above order into verbal orders.