REMICADE

Lake Mary, FL toll free 855.733.3126 toll free fax 888.315.3270
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

DATE: _____ NEEDS BY DATE: _____ **SHIP TO:** ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFO

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: ❑ PRESCRIPTION CARD FRONT & BACK ❑ CLINICAL NOTES ❑ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____ (ICD-10): _____

Please Attach Supporting Labs and Provide Medication List

Drug Allergies: _____

PRESCRIPTION INFORMATION

DATE OF NEXT INFUSION: _____ /_____ / _____ CURRENT WEIGHT: _____lb/kg

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

❑ MD OFFICE
❑ INFUSION CLINIC
NAME: _____
PHONE: _____
❑ HOME INFUSION
HOME HEALTH AGENCY: _____
PHONE: _____
❑ KROGER 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	❑ 25MG ❑ PO ❑ 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:

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date

Prescriber's Signature (no stamps) Dispense As Written Date