Zarina Pharmacy
SPECIALTY & INFUSION

Skip this form & e-prescribe! Select BioPlus from your EHR

SOLID ORGAN TRANSPLANT

Fax: 832-886-4298
Phone: 832-886-4296
zarinapharmacy.com

Ship To/Site of Care: ☐ **In Office** ☐ **Infusion Suite** ☐ **At Home** ☐ **Other:** _____

PATIENT INFORMATION

Name:		SSN:		DOB:
Address:		City:	State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender: ◉ Female ◉ Male
Email:				

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy#:	Group#:

CLINICAL INFORMATION

Diagnosis (ICD-10): ☐ 294.0 Kidney Transplant ☐ 294.1 Heart Transplant ☐ 294.2 Lung Transplant ☐ Other: _____ Date of Diagnosis: _____
Has patient received immune globulin previously? ☐No ☐ Yes: Date of last infusion: _____ Date of next infusion: _____
Comorbidities: _____
Allergies: ☐ NKDA ☐ Other: _____

Please included the following information: ☐ Demographics ☐ H&P ☐ Physician Orders ☐ Insurance Information ☐ Labs

PRESCRIPTION INFORMATION (or attach a copy of prescription)

Infusion Therapy:
Preferred brand _____ **OR** ☐ Pharmacist will determine appropriate product based on clinical assessment, insurance requirements, and availability
☐ No Substitute ☐ Refills: _____ times (as allowed by state or payer requirements)

Dose: *(please select option(s) and provide complete information, pharmacy to round the nearest 5 gram vial)*
☐ Administration Rate = Follow Manufacturer's Guidelines
☐ Loading Dose: _____ gm/kg over ____ days, then
☐ Maintenance dose: ____ gm/kg over ____ days, every ____ weeks x ____ cycles
☐ Other Regimen: _____

Infusion Rate: *(please select one and provide complete information)*
☐ Pharmacist to determine
☐ Start at _____ mL/hr, then increase by _____ mL/hr every ____ minutes
to maximum rate _____ mL/hr

Vascular Access Device:
☐ Peripheral Catheter ☐ PICC ☐ Port
☐ Other (describe # of lumens): _____
Flush Orders: (If IV ordered, the following flush protocols will be followed)
☐ **Sodium Chloride 0.9%**
Peripheral Line: 3 mL before each dose and 3 mL after each dose and PRN
Central Line: 5-10 mL before each dose and 5-10 mL after each dose and PRN
☐ **Heparin 10 u/mL** Peripheral Line: 3 mL after last sodium flush and PRN
☐ **Heparin 100 u/mL** Central Line: 5 mL after last sodium flush and PRN
Provide needles, syringes, VAD supplies & other ancillary supplies needed for infusion

Hydration Orders:
Infuse ___ mg _____ solution ☐ Prior to ☐ Following

Labs:
Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only. Labs will not be drawn on weekend/holidays. Not appropriate for STAT labs
☐ Quantitative Ig A prior to first dispense. Pharmacist to obtain authorization from MD.
☐ Other: _____ Frequency of Labs: _____

Pre-Medication:
Diphenhydramine
25 mg capsule: 1-2 capsules PO 15-30 minutes before each infusion ☐ Decline
Acetaminophen
650 mg tablet: 1-2 tablets PO 15-30 minutes before each infusion ☐ Decline
☐ Other: _____ Strength: _____
Directions: _____

Anaphylaxis Kit Order (Infusion Reaction Management x1/year)
STOP INFUSION IMMEDIATELY.
Administer reaction management medications.
- Acetaminophen (Tylenol) 500 mg PO every 4 hours PRN myalgia or fever > 101.3
- Diphenhydramine (Benadryl) 25 mg IV every 4 hours PRN urticarial, pruritus, or shortness of breath.
- If symptoms are rapidly progressing or continue after the diphenhydramine: give epinephrine (1:1000 strength) 0.3 mL SUBQ. May repeat every 10-15 mins.

Notify Physician immediately for any new onset of the following life threatening hypersensitivty reactions to include fever, chills, dyspnea, pruritus, urticarial, convulsions, erythematous rash, hypotension, back pain, sudden chest pain, or hypertension. Call 911 as appropriate.

☐ **Diphenhydramine 50 mg/1 mL**
IM/ IV Dose: Adult = 10-50 mg per dose every 24 hours to a maximum of 400 hours. Administer as an IV push over 5 minutes.

☐ **Epinephrine 1:1000 (1 mg/1 mL)**
SUBQ Dose: Adult = 0.2-0.5 mL per dose every 15-30 minutes for 3-4 doses or every 4 hours as needed.

NURSING

☐ **Nursing Agency:** _____ **Phone:** _____
Skilled Nursing Visits for infliximab intravenous administration and education. To provide education related to the disease process and therapy.
To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:	
Office Contact:		Email:	
Address:	City:	State:	ZIP:
NPI #:		Tax ID:	
Prescriber Signature:		Date:	