

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s).	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)																											
Diagnosis: <input type="checkbox"/> M06.9 (Rheumatoid Arthritis) <input type="checkbox"/> K50.9 (Crohns) <input type="checkbox"/> L40.5 (Psoriatic Arthritis) <input type="checkbox"/> K51.8 (Ulcerative Colitis) <input type="checkbox"/> M45.9 (Ankylosing Spondylitis) <input type="checkbox"/> Other _____																											
Diagnosis Date: _____		TB test: Yes No Negative Test Date: _____																									
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Prior Therapy</th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> <th style="width: 45%;">Reason for Discontinuation of Therapy</th> <th style="width: 15%;">Approximate Start Date</th> <th style="width: 5%;">Approximate End Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Prior Therapy	Yes	No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	Comorbidities: _____		
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_____	_____	_____	_____	_____	_____																						
Concomitant Medications: _____																											
Allergies: _____																											

Prescription	
<p>Flushing Orders: • Per CoxHealth at Home protocol PIV: 0.9% Sodium Chloride 3-20 ml before and after infusion as needed Port : Bacteriostatic 0.9% Sodium Chloride 3-20ml into port at time of access or at least monthly, 0.9% Sodium Chloride 3-20 ml before and after infusion and as needed, Heparin 100units/ml 5ml as lock after infusion</p> <p>Pre-Medication Orders: <input type="checkbox"/> Diphenhydramine _____ mg PO 30 minutes prior to infusion <input type="checkbox"/> Diphenhydramine _____ mg IV in 10ml NS 15-30 minutes prior to infusion <input type="checkbox"/> Acetaminophen 650mg PO 30 minutes prior to infusion <input type="checkbox"/> Other: _____</p> <p>Remicade (infliximab): Frequency: <input type="checkbox"/> 3 doses at weeks 0,2 and 6 followed by infusions every _____ weeks thereafter OR <input type="checkbox"/> Maintenance: every _____ weeks</p> <p>Dose: RPh will round up to the nearest vial size (100mg) or <input type="checkbox"/> Give the exact dose (do NOT round) <input type="checkbox"/> 5mg/kg IV over at least 2 hours <input type="checkbox"/> 3mg/kg IV over at least 2 hours <input type="checkbox"/> Other _____ IV over at least 2 hours</p> <ul style="list-style-type: none"> • Dilute in 250ml 0.9% Sodium Chloride to a final concentration of 0.4 to 4mg/ml • First doses will follow CoxHealth at Home infusion rate protocol <p>Duration: <input type="checkbox"/> Refills x 1 year OR <input type="checkbox"/> _____ infusions</p>	<p>LABS: <input type="checkbox"/> with each infusion OR <input type="checkbox"/> every _____ <input type="checkbox"/> CBC with Diff <input type="checkbox"/> Hepatic function panel <input type="checkbox"/> Serum Creatinine <input type="checkbox"/> Other: _____</p> <p>Note: • Orders are initiated unless crossed out by provider</p>

Prescriber's Signature: _____	Date: _____
I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home	

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 1-855-419-4663 to obtain instructions as to the proper destruction of the transmitted material. Thank you.