

**IWK Special Immunization Clinic**  
**Referral for infant exposed to biologic monoclonal antibodies in utero**  
**Please fax referral form to 902-470-7232**

Patient Name: \_\_\_\_\_  
 ID#: \_\_\_\_\_  
 D.O.B: \_\_\_\_\_  
 Gender: \_\_\_\_\_  
 Location: \_\_\_\_\_  
 HCN: \_\_\_\_\_

**Prenatal consult:**   
 Current Gestational Age: \_\_\_\_\_  
 Expected Date of Delivery: \_\_\_\_\_  
**Indications:**  
 Rituximab (Rituxan®)                       Patient Request  
 Belimumab (Benlysta®)  
 Natalizumab (Tysabri®)

<b>POSTNATAL CONSULT:</b> <input type="checkbox"/>	<b>YES</b>
<b>BIOLOGIC MONOCLONAL ANTIBODIES RECEIVED DURING PREGNANCY</b>	
1. TNF $\alpha$ inhibitors (including biosimilars): Infliximab (Remicade®), Adalimumab (Humira®), Golimumab (Simponi®)	<input type="checkbox"/>
2. TNF $\alpha$ inhibitors: Etanercept (Enbrel®)	<input type="checkbox"/>
3. Anti-CD20 agent: Rituximab (Rituxan®), Belimumab (Benlysta®)	<input type="checkbox"/>
4. Anti- $\alpha$ 4 integrin: Natalizumab (Tysabri®)	<input type="checkbox"/>
5. Anti- $\alpha$ 4 $\beta$ 7 integrin: Vedolizumab (Entyvio®)	<input type="checkbox"/>
6. Co-stimulation blockade: Abatacept (Orencia®)	<input type="checkbox"/>
7. Anti-IL12/IL23: Ustekinumab (Stelara®)	<input type="checkbox"/>
8. Other: _____	<input type="checkbox"/>
Last dose of biologics (to be) given: _____ weeks prior to delivery	
Most recent maternal drug level obtained (if available): _____ Date: _____	
Other information : _____ _____	
<b>UNDERLYING MATERNAL CONDITION (REASON FOR BIOLOGICS)</b>	

**Note: No referral required for patients on Certolizumab pegol (Cimzia®) – due to lack of transfer of drug across the placenta.**

**Please FAX completed form to Karen Branscombe at 902-470-7232 or [sicnurse@iwk.nshealth.ca](mailto:sicnurse@iwk.nshealth.ca)**

**Specify: Infant Exposed to Biologics in Utero**

**Questions: Call Karen at 902-470-7859 or email [sicnurse@iwk.nshealth.ca](mailto:sicnurse@iwk.nshealth.ca)**