

Gastroenterology Order Form

Fax Completed Form To:

Phone:

PATIENT INFORMATION			
Patient Name:	Date of Birth:	Referral Date:	
Address:	City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	☐ Male ☐ Female
Patient Diagnosis & ICD-10:			
Allergies:			

PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:	NPI#:	
Address:	City/State/Zip:	
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

PLEASE ATTACH	
☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)	☐ TB lab results within last 12 months
☐ Recent office visit notes, history & physical, lab & pertinent procedure results	☐ HBV lab results within last 12 months (<i>Infliximabs only</i>)
☐ Current medication list & list of prior medications tried and failed (with dates)	☐ Liver enzymes lab results (<i>Skyrizi only</i>)
☐ Line access documentation/verification if applicable	☐ Bilirubin levels (<i>Skyrizi only</i>)
☐ Vaccine status (any vaccination) and documentation of any recent vaccinations	☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS	
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.	
Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - ☐ 10units/mL -OR- ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line	
Lab Orders: Lab Date & Frequency:	

PRESCRIPTION ORDERS	
Anaphylaxis Kit: (Check all that apply)	☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed ☐ Diphenhydramine _____ mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Other _____
Pre-Medications: (Check all that apply)	☐ Acetaminophen _____ mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____ mg IV _____ minutes prior to infusion ☐ Diphenhydramine _____ mg ☐ PO ---OR--- ☐ IV _____ minutes prior to infusion ☐ Other _____
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary	

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given? _____ When is patient due for next dose? _____		
☐ ENTYVIO	☐ Induction: 300mg IV infusion over 30 minutes at week 0, 2, and 6 ☐ Maintenance: 300mg IV infusion over 30 minutes every _____ weeks ---OR--- Prefilled Pen 108mg SC every 2 weeks starting at week 6	NONE
☐ INFlixIMAB ☐ AVSOLA ☐ INFLECTRA ☐ RENFLEXIS ☐ ZYMFENTRA	☐ Induction: _____ mg/kg or _____ mg IV infusion via ☐ gravity ---OR--- ☐ pump over at least 2 hours at weeks 0, 2, and 6 ☐ Maintenance: _____ mg/kg _____ mg IV infusion via ☐ gravity ---OR--- ☐ pump over at least 2 hours every _____ weeks (Note: Round to nearest 100mg for Medicaid patients) ☐ Maintenance: 120 mg SC every 2 weeks starting at week _____. If Zymfentra, initiating SUBQ maintenance therapy after IV induction therapy: 120 mg every 2 weeks starting at week 10. Switching from IV maintenance therapy: 120 mg every 2 weeks starting in place of the next scheduled IV maintenance dose.	NONE
☐ OMVOH	☐ Induction (UC): 300mg IV infusion via ☐ gravity ---OR--- ☐ pump over 30 minutes at week 0, 4, and 8 ☐ Maintenance: 200mg SC injection, given as two consecutive injections of 100mg each at Week 12, and every 4 weeks thereafter ☐ Induction (Crohn's): 900mg IV infusion via ☐ gravity ---OR--- ☐ pump over 30 minutes at week 0, 4, and 8 ☐ Maintenance: 300mg SC injection, given as two consecutive injections of 100mg + 200mg (or 100mg x 3) at Week 12, and every 4 weeks thereafter	NONE
☐ SKYRIZI	☐ Induction (Crohn's): 600mg IV infusion via ☐ gravity ---OR--- ☐ pump over one hour at week 0, 4, and 8 ☐ Maintenance: ☐ 180mg or ☐ 360mg SC injection at Week 12, and every 8 weeks thereafter ☐ Induction (UC): 1200mg IV infusion via ☐ gravity ---OR--- ☐ pump over two hours at week 0, 4, and 8 ☐ Maintenance: ☐ 180mg or ☐ 360mg SC injection at Week 12, and every 8 weeks thereafter	NONE
☐ STELARA (Ustekinumab) ☐ SELARSDI (Ustekinumab) ☐ YESINTEK (Ustekinumab-krce)* ☐ WEZLANA (Ustekinumab-aauub) ☐ STARJEMZA (Ustekinumab-hmny) ☐ OTULFI (Ustekinumab-aauz)* *Interchangeable biosimilar	Induction (Adult Dosing -Based on body weight of patient at time of dosing): ☐ For patients 55kg or less administer 260mg IV infusion via ☐ gravity ---OR--- ☐ pump over at least 1 hour x 1 dose ☐ For patients more than 55kg to 85kg administer 390mg IV infusion via ☐ gravity ---OR--- ☐ pump over at least 1 hour x 1 dose ☐ For patients more than 85kg administer 520mg IV infusion via ☐ gravity ---OR--- ☐ pump over at least 1 hour x 1 dose ☐ Maintenance: 90mg SC injection _____ weeks after induction and every _____ weeks thereafter	NONE
☐ TREMFYA	☐ Induction (Crohn's AND UC): 400mg (as 2 consecutive 200mg injections) SC induction on weeks 0, 4, and 8 ☐ Induction (Crohn's AND UC): 200 mg IV infusion via ☐ gravity - OR - ☐ pump over at least 1 hour at week 0, 4, and 8 ☐ Induction and Maintenance (Plaque psoriasis, Psoriatic arthritis): 100 mg SC at weeks 0, 4, then every 8 weeks thereafter ☐ Maintenance: 100mg SC injection every 8 weeks beginning at week 16 ☐ Maintenance: 200mg SC injection every 4 weeks beginning at week 12	NONE
☐ OTHER		NONE

Prescriber's Signature _____ Print Name _____ Date _____
Dispense as Written

Prescriber's Signature _____ Print Name _____ Date _____
Substitution Permitted

