Gastroenterology Medication

Date: _____
Patient Name: _____
Date of Birth: _____

Fax Referral To:
877-438-9380

CONTINUUMRx™
Specialty Infusion Services
In Partnership with Major Health Systems

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

DIAGNOSIS

Description ◯ Crohn's Disease ◯ Ulcerative Colitis | **ICD-10 Code** ◯ K50.0 ◯ K51.9

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

◯ This signed order form ◯ History and Physical ◯ Tysabri Touch Authorization ◯ TB and Hep B Documentation
◯ Patient Demographics and Insurance Information ◯ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient weight: _____ Lbs Height: _____ Inches Allergies: _____
Line Access: ◯ PIV ◯ PICC (SL DL TL) ◯ PORT ◯ Sub-Q

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
◯ Entyvio	300mg vial	◯ Initiation - Infuse 300mg IV over 30 minutes at week 0, 2, and 6 ◯ Maintenance - Infuse 300mg IV over 30 minutes every 8 weeks	Baseline Liver Enzymes TB Skin Test	_____
◯ Remicade	100mg vial	◯ Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0, 2, and 6 ◯ Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks	TB Skin Test Hepatitis B protocol	_____
◯ Inflectra	100mg vial	◯ Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0, 2, and 6 ◯ Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks	TB Skin Test Hepatitis B protocol	_____
◯ Renflexis	100mg vial	◯ Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0, 2, and 6 ◯ Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks	TB Skin Test Hepatitis B protocol	_____
◯ Stelara	◯ 130mg vial ◯ 90mg PFS	◯ Initiation - <55kg 260mg; 55-85kg 390mg; >85kg 520mg IV infusion over 60 minutes x 1 dose ◯ Maintenance - Inject 90mg SQ every 8 weeks	TB Skin Test	_____
◯ Tremfya	◯ 100mg SmartJect ◯ 100mg PFS	◯ Initiation - Infuse 200mg IV at week 0, 4 and 8 ◯ Maintenance - Subcutaneous maintenance doses must be sent to patient's preferred pharmacy	TB Skin Test CBS with Diff	_____
◯ Tysabri	300mg vial	Infuse 300mg IV over 60 minutes every 4 weeks		_____

Premedication(s)

◯ Diphenhydramine 25-50 mg po - 25mg #2 per dose
◯ Acetaminophen 325-650 mg po - 325mg #2 per dose
◯ Methylprednisolone _____ mg IV over _____ mins
◯ Other: _____

Ancillary orders will include:

NaCl 0.9% 5-10ml IV before and after infusion
Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN All infusion supplies necessary to administer the medication Anaphylaxis Kit

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician signature: _____ Date: _____

Physician name: (Please print) _____

Phone: _____ Fax: _____ License #: _____ NPI #: _____