

Gastroenterology Medication

Fax Referral To:
877-438-9380



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

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

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. Drug names are the property of their respective owners. The information contained in this document may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the document or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 800-665-2850 or faxing back to the originator. ©2024 ContinuumRx Services, Inc. All rights reserved. "The content is not intended to diagnose, treat, or cure any medical condition. Individual experiences with infusion therapy may vary, and healthcare decisions should always be made in consultation with a qualified healthcare provider who can offer personalized advice based on a person's medical history and condition. By accessing this content, you agree to hold harmless the author, publisher, and any associated parties from any claims, liabilities, or damages arising from the use or interpretation of this content."