Gastroenterology Medication Fax Referral To: 877-438-9380 Date: Patient Name: In Partnership with Major Health Systems 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) TB and Hep B Documentation This signed order form History and Physical Tysabri Touch Authorization 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: Height: Inches Allergies: PICC (SL DL TL) PORT Line Access: PIV Sub-O **MEDICATION** DOSE LAB & ANCILLARY ORDERS REFILLS **DIRECTIONS** Initiation - Infuse 300mg IV over 30 minutes at week 0, 2, and 6 Baseline Liver Enzymes TB 300mg vial Entyvio Skin Test Maintenance - Infuse 300mg IV over 30 minutes every 8 weeks Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0, 2, and 6 TB Skin Test Hepatitis 100mg vial Remicade Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks B protocol Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0, 2, and 6 TB Skin Test Hepatitis 100mg vial Inflectra Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks B protocol Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0, 2, and 6 TB Skin Test Hepatitis Renflexis 100mg vial Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks B protocol 130mg Initiation - <55kg 260mg; 55-85kg 390mg; >85kg 520mg IV TB Skin Test Stelara vial infusion over 60 minutes x 1 dose 90mg PFS Maintenance - Inject 90mg SQ every 8 weeks 100mg Initiation - Infuse 200mg IV at week 0, 4 and 8 TB Skin Test Tremfya SmartJect Maintenance - Subcutaneous maintenance doses must be sent to patient's CBS with Diff 100mg PFS Infuse 300mg IV over 60 minutes every 4 weeks Tysabri 300mg vial Ancillary orders will include: 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: __

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: _____ Physician name: (Please print) License #:______ NPI #:____ Fax:_____

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