GASTROENTEROLOGY INFUSION ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: ____ DOB: ___________________ Phone: ______________________________

MEDICAL INFORMATION

Patient Weight: _____________ lbs./kg. (required) Allergies: ____

THERAPY ORDER

Diagnosis	Medication Orders	Refills
☐ Dehydration ☐ Diverticulitis ☐ Gastroenteritis **ICD-10:** ______________	1 Liter 2 Liters D5 0.45 NS IV x 1 day 1 Liter 2 Liters NS IV x 1 day 1 Liter 2 Liters Lactated Ringer's IV x 1 day Other: ____	
☐ Iron Deficiency Anemia ☐ Iron Deficiency Anemia with CKD not on dialysis **ICD-10:** ______________ ****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first****	☐ **Venofer** 200mg IV – Administer 5 doses over a 14-day period ☐ **Venofer** 200mg IV weekly x 5 weeks ☐ **Injectafer** 15mg/kg IV (<50kg) – Give 2 doses at least 7 days apart ☐ **Injectafer** 750mg IV (>50kg) – Give 2 doses at least 7 days apart ☐ **Monoferric** 20mg/kg IV x 1 dose (<50kg) ☐ **Monoferric** 1000mg IV x 1 dose (>50kg)	
☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other : _______________ **ICD-10:** _____________	☐ **Cimzia** 400mg SubQ at weeks 0, 2, 4 and then every 4 weeks ☐ **Cimzia** ________ mg SubQ every _______ weeks ☐ **Infliximab or infliximab biosimilar** as required by the patient's insurance Dose: _________ mg/kg Frequency: Every ______ weeks OR 0, 2, 6, then every 8 weeks Do not substitute. Infuse the following infliximab product: ___________________________ ☐ **Skyrizi** initial infusion: 600mg IV at week 0, 4, and 8 weeks ☐ **Skyrizi** maintenance: 360mg Sub-Q at week 12 and then every 8 weeks ☐ **Stelara** initial infusion: ☐ 260mg IV x 1 dose (<55kg) ☐ 390mg IV x 1 dose (55-85kg) ☐ 520mg IV x 1 dose (>85kg) ☐ **Stelara** maintenance: 90mg SubQ 8 weeks after initial infusion and then every 8 weeks ☐ **Tysabri** 300mg IV every 4 weeks ☐ **Entyvio** 300mg IV at 0, 2, 6 weeks and then every 8 weeks ☐ **Entyvio** 300mg IV every 8 weeks	☐ x 1 year ☐ ___________

Premedication orders: Tylenol 1000mg OR 500 mg PO
Please choose one antihistamine: Diphenhydramine 25mg PO Loratadine 10mg PO Cetirizine 10mg PO Other: _____________________
Additional premedications: Solu-Medrol __________ mg IVP Solu-Cortef _________ mg IVP Other: ___________________________________

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: ________________________________ Signature: _______________________________ Date: ___________________

Provider NPI: ________________________ Phone: _______________________ Fax: ____________________ Contact Person: ________________

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