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: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Medication Orders	Refills
☐ Iron Deficiency Anemia ☐ Iron Deficiency Anemia with CKD **ICD-10:** _____	☐ **Infed** _____mg OR _____ mg/kg – Give 25 mg test dose 1 hr prior to infusion ☐ **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 or ☐ 1200mg IV at week 0, 4, and 8 weeks ☐ **Skyrizi** maintenance: ☐180mg or ☐ 360mg subQ at week 12 then every 8 weeks ☐ **Stelara** initial infusion: ☐ 260mg ☐ 390mg ☐ 520mg IV x 1 dose ☐ **Stelara** maintenance: 90 mg subQ 8 weeks after initial infusion and then every 8 weeks ☐ **Entyvio** 300mg IV at 0, 2, 6 weeks and then every 8 weeks ☐ **Entyvio** 300mg IV every 8 weeks ☐ **Omvoh** initial infusion: ☐300mg or ☐ 900mg IV at 0, 4, and 8 weeks ☐ **Omvoh** maintenance: ☐200mg or ☐ 300mg subQ at week 12 then every 4 weeks ☐ **Tremfya** initial infusion: 200 mg IV at 0, 4, and 8 weeks ☐ **Tremfya** maintenance: ☐100 mg subQ at week 16, then every 8 weeks OR ☐ 200 mg subQ at week 12, then every 4 weeks Premedication Orders: ☐ **Tylenol:** ☐ 500mg or ☐ 650mg or ☐ 1000 mg PO ☐ **Benadryl:** ☐ 25mg or ☐ 50mg ☐ PO or ☐ IV ☐ **Other antihistamines:** ☐ **Loratadine** 10 mg PO or ☐ **Fexofenadine** 60 mg PO or ☐ **Cetirizine** 10 mg PO ☐ **Solu-Medrol:** _____ mg IVP ☐ **Solu-Cortef:** _____ mg IVP	☐ x 1 year _____

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: _____

ACTIVE infusions

COMPREHENSIVE SUPPORT FOR GASTROENTEROLOGY THERAPY

P: 240-200-4464 F: 240-892-3005

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete previous page)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's mediation list
- ☐ Supporting clinical notes (H&P) to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
    - ☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., 6MP, azathioprine)? ☐ Yes ☐ No
      If yes, which drug(s)? _____
    - ☐ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Humira, Stelara, Cimzia)? ☐ Yes ☐ No
      If yes, which drug(s)? _____
- ☐ Include labs and/or test results to support diagnosis (attach)
- ☐ *If applicable* – Last known biological therapy: _____ and last date received: _____.
  If patient is switching biologic therapies, please perform a wash out period of _____ weeks prior to starting ordered biologic therapy.
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING (BASED ON DRUG THERAPY)

- ☐ **TB screening test completed within 12 months – attach results**
  Required for: Cimzia, Infliximab, Stelara, Entyvio, Skyrizi, Omvoh, Tremfya
  ☐ **Positive** ☐ **Negative**
- ☐ **Hepatitis B screening test completed (Hepatitis B surface antigen) – attach results**
  Required for: Cimzia, Infliximab
  ☐ **Positive** ☐ **Negative**
- ☐ **Liver function tests & bilirubin** Required for: Skyrizi, Omvoh
- ☐ **Labs indicating iron deficiency** Required for: Injectafer, Monoferric

*If TB or Hepatitis B results are positive please provide documentation of treatment or medical clearance and a negative CXR (TB+)

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance