



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
<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> Iron Deficiency Anemia with CKD ICD-10: _____	<input type="checkbox"/> Infed _____ mg OR _____ mg/kg – Give 25 mg test dose 1 hr prior to infusion <input type="checkbox"/> Injectafer 15mg/kg IV (<50kg) – Give 2 doses at least 7 days apart <input type="checkbox"/> Injectafer 750mg IV (>50kg) – Give 2 doses at least 7 days apart <input type="checkbox"/> Monoferric 20mg/kg IV x 1 dose (<50kg) <input type="checkbox"/> Monoferric 1000mg IV x 1 dose (>50kg)	
<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Other : _____ ICD-10: _____	<input type="checkbox"/> Cimzia 400mg subQ at weeks 0, 2, 4 and then every 4 weeks <input type="checkbox"/> Cimzia _____ mg subQ every _____ weeks <input type="checkbox"/> Infliximab or infliximab biosimilar as required by the patient's insurance Dose: _____ mg/kg Frequency: <input type="checkbox"/> Every _____ weeks OR <input type="checkbox"/> 0, 2, 6, then every 8 weeks <input type="checkbox"/> Do not substitute. Infuse the following infliximab product: _____ <input type="checkbox"/> Skyrizi initial infusion: <input type="checkbox"/> 600mg or <input type="checkbox"/> 1200mg IV at week 0, 4, and 8 weeks <input type="checkbox"/> Skyrizi maintenance: <input type="checkbox"/> 180mg or <input type="checkbox"/> 360mg subQ at week 12 then every 8 weeks <input type="checkbox"/> Stelara initial infusion: <input type="checkbox"/> 260mg <input type="checkbox"/> 390mg <input type="checkbox"/> 520mg IV x 1 dose <input type="checkbox"/> Stelara maintenance: 90 mg subQ 8 weeks after initial infusion and then every 8 weeks <input type="checkbox"/> Entyvio 300mg IV at 0, 2, 6 weeks and then every 8 weeks <input type="checkbox"/> Entyvio 300mg IV every 8 weeks <input type="checkbox"/> Omvoh initial infusion: <input type="checkbox"/> 300mg or <input type="checkbox"/> 900mg IV at 0, 4, and 8 weeks <input type="checkbox"/> Omvoh maintenance: <input type="checkbox"/> 200mg or <input type="checkbox"/> 300mg subQ at week 12 then every 4 weeks <input type="checkbox"/> Tremfya initial infusion: 200 mg IV at 0, 4, and 8 weeks <input type="checkbox"/> Tremfya maintenance: <input type="checkbox"/> 100 mg subQ at week 16, then every 8 weeks OR <input type="checkbox"/> 200 mg subQ at week 12, then every 4 weeks Premedication Orders: <input type="checkbox"/> Tylenol: <input type="checkbox"/> 500mg or <input type="checkbox"/> 650mg or <input type="checkbox"/> 1000 mg PO <input type="checkbox"/> Benadryl: <input type="checkbox"/> 25mg or <input type="checkbox"/> 50mg <input type="checkbox"/> PO or <input type="checkbox"/> IV <input type="checkbox"/> Other antihistamines: <input type="checkbox"/> Loratadine 10 mg PO or <input type="checkbox"/> Fexofenadine 60 mg PO or <input type="checkbox"/> Cetirizine 10 mg PO <input type="checkbox"/> Solu-Medrol: _____ mg IVP <input type="checkbox"/> Solu-Cortef: _____ mg IVP	<input type="checkbox"/> 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: _____

ACTIVEINFUSIONS.COM

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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 medication 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)?
For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Humira, Stelara, Cimzia)?
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
Hepatitis B screening test completed (Hepatitis B surface antigen) - attach results
Required for: Cimzia, Infliximab
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

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ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

Phone Call Text Message Email No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder?

Yes No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION